Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Philip Clayton Gordy Jr. 11.30 11 06 2004 4c. County of Death < 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Nicomica Keylonal enter lisbure If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F 49 220-68-8352 2/4/1958 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b: County 1 XYes 2 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 USA 222 Monticello Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: Specifiwhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) accounting accountant 18. Mother's Name (First, Middle, Maiden Surname) Beverly Adkins Philip Clayton Gordy Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 Old Ocean City Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11/8/07 Salisbury Crematory Salisbury, MD

17. Father's Name (First, Middle, Last)

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be

event, the Medical

Department of Health Important: If item 27 any injury or other tr

Physician /Medical

Examiner

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page 2

director

After th funeral

e Hospital or Attending Pi 24 hours after death. e Funeral Director; After the letely filled in by the funeral

To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b.

certificate

attending physician

law requires that the death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

Director

Funeral

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Examiner

Physician/Medical

Completed by

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Certification:

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Maryland 21215-0036

Baltimore,

Philip C. Gordy Sr/father

1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural Funcial Service Cense

²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

22a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only ofe cause on each line. diate Cause (Final disease or condition resulting in death) Due to (or as a Anse Mence of): Due to (or as a consequence of)

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably 4 Onknown

24a. Was an autopsy performed? Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 2 No

1 ☐ Yes 27. Manner of Death 1 Natural

2 Accident

3☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day

3 □ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CANOY 35.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Day 1:07AM E. Gray November 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Coastal Haspice at the 5. Social Security Number 6. Sex Wicomico 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. Birthplece (State or Foreign Country)
 Washington **Funeral** Months 1 ☑ M 2 ☐ F 92 10/27/1915 Director 539-05-7984 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r 28a-f show Wicomico 1 ☐ Yes 2 X No Maryland Salisbury Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? w items 23e or 3 1319 Toadvine Rd. 21804 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married 1XYes 2 No 2 If Yes, Give Year or Dates: Navy 1 Yes 28 No þ Specify the Medical Exer Specify: white 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Automobile Shippers Inc Ith and Mental Hygie 27 Is marked other I traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Jeremiah Andrew Gray Jessie Melvina Deweese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lila M. Wendell/sister if itam 27 l 1319 Toadvine Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Department of Important: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 11/13/07 Salisbury, MD 21. Signature of Funeral Service Licensee ² Name and Address of Facility Holloway Funeral Home Professional Association tarid 501 Snow Hill Rd., Salisbury, MD 21804 Udompsons (FSP 23a. Part1. Enter the disease, or complications that exused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEVBRE AORTIC /Medical Due to (or as a consequence of) Examiner TRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit MULTIPLA DRCUBITUS ULCANS SACRAL Due to (or as a consequence of): physicien Physiclan/Medical the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 Ro
9 Unknown Month Day 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 □Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes All No 24a. Was an autopsy performed? certificate has t 1 ☐ Yes 2€No director Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3ETNO Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Yes this After thi 28a. ate of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident the Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide after 0 To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 84 20053410 5 IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day (Jegr) 1 3 20072. Register Statute

Registrar

Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 38003

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	R	egistrar . Decedent's Name (First, Midd	le.Last)		- Cortinoate						Date of Dea	ath		3. Time of Dea	
Physicia Medical Examin	er	LAWRENCE	HAYTH								Month Novembe		Year 2007 c. County of Death	1015 hrs	<u>;</u>
4	I	a. Facility Name (if not institution		ımber)		41	b. City, Tov Chever		cation of L	Death			Prince George		
		Prince Georges Hosp 5. Social Security Number	6. Sex	7. Age (In	yrs. last birthda	y)	If Under		If Under 2	24Hrs.	3. Date of B	irth(MN	//DD/YYYY) 9. Bir	thplace (State	or OT
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral [11. Marital Status 1 Never Married 2 X	12. Was De	orces?		3. Was	s Decedent es, specify	of Hispa Cuban, I	anic Origin Mexican, F	? (Spec Puerto Ri	cify Yes or Nican, etc.)	No-	14. Race - Ame White, etc.	rican Indian, Bl	ack,
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To the Hos within 24 h To the Fun	Medical	one) 2 Medical	and mani	er stated.	ination and/or ii	ivesiiç			se number				29d. Date signed		
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		30. Name and address of pe	_												
GR (10)		Donna M. Vincenti	, MD Assista	nt Medic	al Examiner		11 Penn	Stree	t, Baltim	ore, N	1D 21201				
Regi	Stat	B2E11/ V '4 /11/1	gar) hours	2. Registrar	's Signature	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:00 P 11/09/2007 Bruce Harrison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince Georges 5705 40th Place If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 175-36-2416 1⊠M 2□F Pennsylvania 1/09/1940 67 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYes 2 □ No Director MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5705 40th Place 20781 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 2X No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Electrical Engineer Dept. Of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Harrison Mary Douglas Gunn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11402 Old Baltimore Pike, Beltsville, MD 20705 Karen Harrison, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory 11/13/2007 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 nnuci 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 2 No 3 Probably 1 Tyes 4 🔀 Unknown Completed Diabetes Mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Be 힏 Medical Certification:

Examiner death certificate be executed physician a Division or Vital Records, P.O. Box 68760 as attending p for use as use the the signed by law requires that has page certificate Hospital or Attending

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Funeral

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28a-f show

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altimore, Maryland 21215-0036

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Pages 1

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27	. Manner of Deatl 1 ⊠ Natural 2 □ Accident	5 ☐ Pending investigation		28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes	2□No	28d. Describe how injury	occurred						
	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of injury - At h building, etc. (Speci	ome, farm, stree fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29	a. Certifier (Check only one)	1X Certifying Ph 2☐ Medical Exam	ysician: To the best of my knoniner: On the basis of examination and manner stated.	owledge, death o ation and/or inve	occurred estigation	at the time, o	late and place on, death occ	ce, and due to the cause(s) a curred at the time, date and p	and manner as stated. place, and due to the cause(s)						

29c. License number

D0058290

29d. Date signed (Month, Day, Year)

11/12/2007



Registrar

29b. Signature and title of certifier

Suresh Muttah 5711 Sarvis Ave., Riverdale, MD 20737 32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Paul Leon Hecker, Jr. Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year November 13, 2007 1436 hrs **Medical Examiner** Leon Hecker Jr 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Salem Church Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Country) Hours Min. Months Davs Director Yrs 1937 1 M 2 F 5 Hagerstown 70 220-34-0844 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ī 10a. State 1 Yes 2 X No 28a-f show or items 23a or 28a-f shormust be notified at once. Maryland Washington Hagerstown death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17542 21740 U.S.A. Swann Road 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes Specify: White Yes 2 No specify: permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. If item 27 is marked other than "natural", oo indiry or ofther tranmatic event, the Medical Examiner. Yes, Give Year Divorced 3 Widowed 5 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Communications 12 Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Alice Kunkleman Paul Leon Hecker Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Road Hagerstown Maryland 21740 Swann_ Sally Anne Hecker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 11/17/2007 Hagerstown Maryland Rest Haven Cemetery 4 Donation 5 Other Specify. 22. Name and Address of FacilityRest Haven Funeral Chapel 21. Si watere of Funeral Service Licen 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death /Medical a. Contact Gunshot Wound of Chest Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial -Records, P.O. Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown icate has been signed by the a page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? certificate has 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: director, Division of Vital Be Hospital: 1 examiner? Other_z Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27, Manner of Death Subject shot self Certification: **FOUND** To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fur 1 Natural Yes 2 🗸 No 5 Pending Nov 13, 2007 1436 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide or Town, State) Salem Church Road , Hagerstown , MD Could not be determined (Specify) Field 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only **Medical** and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi November 14, 2007 O.C.M.E. f person who completed cause of death (Item 23a) DCM 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Mary GARipple MD. 05H-12 32 Redistrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001 OCME 2006

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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Sing Sing After funer	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatio 3 Suicide 6 Could not be determined	28a. Date of (Month)	Injury Day Year) finjury - At h	28b. Time of Injury	М	28c. Injury Work	4 LI NUI	lo 28	e 5 Resid	ow injury	occurred Number	i :	Livin	g
I s I s		29a. Certifier (Check only one) (Check only one)	nvsician: To the b	est of my kno	owledge, death	occurre	d at the tim	e, date and	l place, ar	nd due to the d	called(e)	and man	ner as sta	ted.	
	Medical	29b. Signature and title of certifier	and manne	r stated.	adul allu/or in		n, in my op Oc. License			2	29d. Date	e signed (Month, Da)
511		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	completed cause		, , , , ,	,	hesd	a Mr	2001						
Stat Registra		31. Date filed (Month, Day, Year)		gištrar's Signa		a de		, PID	2001			_			

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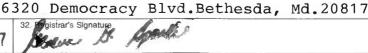
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** $N_{\text{OV}}^{\text{Month}} \cdot 9 \cdot 20^{9} \cdot 0.7$ 2214 M Frieda Hammerschlag /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/18/1914 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 92 Months Days Hours Min. 084-50-8290 1 □ M 212 F Germany Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show MDMontgomery Kensington 1 XYes 2 No Examiner must be notified Director 10g. Citizen of What Country? ъ 4301 Knowles Avenue 20895 USA 'natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other that any injury or other traumatic event, the ones. 8 Restaurant Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 3e David Heimann Regina Philipsohn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris S.Anisman/Daughter 10105 Summit Avenue Kensington, Md. 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 3X Pamoval from State Beth Hillel Cem. 11/13/2007 Walden, New York 5 Other (Specific 4 Donatio 21. Signat A Funeral Service PHIMIP ADIERTINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Urosepsis resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Congestive heart failure that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, PO. Box 68760. attending physician for use as the buria Hypertension Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? atrial fibrillation, dememtia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autonsy performed? res 2⊠No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 🖎 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

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29b. Signature and title of certifier

Ajay Reddy MD 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D53691

29d. Date signed (Month, Day, Year)

Nov.11,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00 16 AM rdlar 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 11168 Oak Lane 21678 Kent Worton, MD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 3-11-1932 Birthplace (State or Foreign Country)

TD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 11 M 2□ F 75 Yrs. 214-28-1282 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other then "naturel; or Items 23s or 28e-f show 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location other treumetic event, the Medical Examiner must be nutilised at Worton 1 ☐ Yes 2 ☐ No MD Kent Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21678 P.O. Box 135 Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1XX Yes 2 □ No
If Yes, Give
Year or Dates: 1952 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Campbell Soup Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillian Wilson Ralph Bordley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11168 Oak Lane Worton, MD Department of Health a Important: If item 27 Is eny injury or other tree Coretta Williams Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-16-07 Hurlock, MD Beulah Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith FH, 717 W. Division St. Dover ammie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à 23e. Did tobacco use controute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☑ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on o Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: esidence 6 ☐Other (Specify) 1 🗌 Yes 3□ DOA 4 Nursing Home 2 this 28d. Describe how injury occurred 27. Mann of Death 28c. Injury at Work? 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) within 29c. License number 296. Signature a 0 2 D36021 2 PAMICH SHAMATAN M.D. 120 SPEW RUCHETERM MD 21670

State

Registrar

30. Name and address of person wh

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Geren & Speck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0 7 1- State Registrar 11/9/07, MS, Kent co. Certificate of Death Amended #26-5 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 930 P M 2007 Leon C. Hansen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14596 Jarrell Road Caroline Goldsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/19/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1X M 2 □ F 202-18-8614 82 Oxford, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Caroline MD Goldsboro 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14596 Jarrell Road 21636 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2X Married White 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Auto Parts Store Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Stallings Harold H. Hansen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy B. Hansen/Wife 14596 Jarrell Road, Goldsboro, MD 21636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/10/07 Oxford Cemetery Oxford, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad St., Middletown, DE 19709 Approximate Interval Between Onset and Death Months Part 1. Enter the disease, or complications that caused the devith. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dancreatic cancer mmediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to or as a conse uence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 😿 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director, After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D057749 5

State Registrar

DHMH 17 Rev 1/2001

219 S. Washington St., Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lakshmi Vaidyanathan MD, 31. Date filed (Month, Day, Year) 32. Registy 's S

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien & UU / Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:34 PM 4a. Facility Name (If not institution, give street and number) HinKS 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisb at Wicomico If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 F Nebraska Director 216-12-8904 93 05/25/1914 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location in then "natural", or Itams 23a or 28e-f show the Medical Examinar is that by notified at 1 XYes 2 ☐ No Completed by Funeral Director Somerset Upper Fairmount 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 8288 Clinton Bozman Road 21867 USA Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Itams 23, ury or other traumatic event, the Medical Example 1. una 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer none Agriculture 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be John Blair Hinks Jeanette Goyette ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Hinks, Jr/son 32053 Gordy Road, Laurel, DE 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or 11/10/2007 4 □ Donation 5 □ Other (Specify) Princess Anne, MD Beechwood Cemetery 22. Name and Address of Facility Hinman Funeral Home 2) Signature of Funeral/Service Coenses M00295 11673 Somerset Ave., Princess Anne, MD 21853 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final HRIMPR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CARONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physicien for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year Month 4 Pregnant at time of death 5 Other (specify) signed by the all d be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 Probably 4 □Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3 ☐ No 24a. Was an page 2 autopsy performed 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only orie Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ patient 1 🗌 Yes 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Chath ate of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28a. 28c. Injury at Work? Certification: Division Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. 24 hours after deat Funerel Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours aft To the Funerel Di completely filled in To the Hospital Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02053410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO DOX 1737 VALIS BURY UD 21802 OHUGAM WARIS COASTAL HOSPICE EB 32. Regetrar's Signature 31. Date filed (Month, Day, Year) State

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ruth Virginia Hayden November 8, 2007 11:50 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf Genesis Waldorf Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 20, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 XF 1921 Virginia 044-14-0521 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X☐ No Director Waldorf Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 US 4140 Old Washington Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker g 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file thent of Health and Mental Hytant: If item 27 Is marked oth Be Earnest Owens Picken Ruth V. Merritt မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29971 Ronald Dr., Mechanicsville, MD 20659 Owens Hayden - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, MD 20601 Trinity Memorial Gdns 11-13-07 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens M00053 22. Name and Address of Facility 3035 Old Washington Road Hack Il Swhamm Waldorf, MD 20601 Huntt Funeral Home 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EUERMOUS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner INBET 72-3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed HTLAVEROSE sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the 9☐Unknown 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>Ş</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25X No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t etely filled in by the funera After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

Registrar

within 24

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29b. Signatule and title of certifier

a address of part in who com

ATTHEW 32. Registrar's Signature

leted cause of death (Item 23a) (Type

and manner stated.

200

29c. License number

29d. Date signed (Month, Day, Year)

206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Mary Hasior 9 2007 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Berlin Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/29/1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 🗙 F 90 150-30-3217 NJUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Ocean Pines Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18 Sundial Circle 21811 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 □ Yes 2 No Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Manager Archdiocese of Newark NJ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter J. Doyle Marie Lands 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Sundial Circle, Ocean Pines, MD 21811 Barbara Schmid / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/12/2007 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. Frankford, DE 21. Signatur of Funeral Service Lie 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications shock, or heart failure. List only one cause Atherosderatic Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to influenate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Medical Examiner muonee.

Hasior, Mary altimore, Maryland 21215-0036

death with

Director

Funeral

Completed by

Be

MD

burial-trar

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical IF FEMALE ģ Completed Be 1 Yes 2 No

(Check only one)

Examiner Certification: To 29a. Certifier Medical

physician the attending for use as director, this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

SA	5

To the Hospital or Attending Physician:

State Registrar

28a. Date of Injury 27. Manner of Death (Month, Day 1 Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

1 Inpatient

Hospital:

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28b. Time of

29c. License number

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nersing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

٠.	Signature and title of Comme	
	MAG.	
	//// / Secure	
*	ane and address of person who completed caus	e of death (Item 23a

tighway Fannak Island, Oc 19944

29d. Date signed (Month, Day, Year)

NOV 1 3 2007

Stephanie Ann Heflin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar		Cert	tificate of	Death					Reg. No.					
Physicia		 Decedent's Name (First, Middle 	Name (First, Middle,Last) 2. Date of Dea													
ledical Examii		Stephanie A	nn Hefli	n						Month Novembe			0928 hrs			
Alixa d		4a. Facility Name (if not institution	n, give street and nu	imber)	4	b. City, Tov		cation of	Death			ounty of De				
		10009 Worrell Avenue				Glenn [Dale				Prin	ce Geor	·ge's			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under	1 Year	If Under	_	8. Date of Bi	rth (MM/DD/		Birthplace (State or	\neg		
Director	- 1	242 22 7266	1 M 2 X F	46	5 Yrs.	Months	Days	Hours	Min.	Feb.	14, 1	961	reign Country) MD.			
	Ļ	213-88-7866 1 M 2 XF 40 Yrs. 1 CD: 147 1301												\dashv		
any	ŀ	10a. State 10b. County		10c. City,	Town or Locati	ion							10d. Inside City Lir	mits		
	- 1	,	G======1=		Glenn							1 Yes 2 No				
-f sho	ğ		George's		Greini	10f. Zip C	odo				10g. Citizen	of What C		\dashv		
Mary Mary	Director	10e. Street and Number				101. ZIP C				Ì	rog. Onizon			1		
th the Maryland 23a or 28a-f show		10009 Worrell						769				USA				
ms 2.	Funeral	11. Marital Status		cedent Ever in U.		s Decedent				rify Yes or N	0- 14.	. Race - An White, etc	merican Indian, Black, c.	l		
death r ite	š	1 Never Married 2 X Ma	arried 1 Yes	i					,,		Τ.	White	- 1			
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland I Hygiene. ed other than "natural", or items 23a or 28a-f she, the Medical Examiner must be notified at once	by F	3 Widowed 4 Div	orced If Yes, Give Yes	ar		Yes 2X						cony.				
ours (aturz cami		15. Decedent's Education (Spe-	cify only highest gra	de completed)	16a. Deceder	nt's Usual O lost of worki	ccupation	n (Give ki	ind of wor	rk done	16b. Kind	of Busine	ess/Industry			
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	duning in	1001 01 110111	ngo. =			-,						
5-0036 ted within 72 Hygiene. other than '	립	12	ŀ		Le	egal S						Lav	<u> </u>			
5-00 led with Hygiens other	Ŝ	17. Father's Name (First, Middle,	Last)				18	3.Mother's	s Name (F	First, Middle,	Maiden Su	rname)				
	Be	Robert L. Mu	ir, Sr.					Joy	rce	KM	iller					
21 Ould 1 Mer mar		19a. Informant's Name/Relations	hip (Type, Print)										itate, Zip Code)			
MD d 2 sho lth and n 27 is numati		Joyce K. Muir /	mother		10009	Worr	ell	Ave.		Glenn			20769			
ore, MD 21218 Stand 2 should be fill of Health and Mental I If item 27 is marked nor traumatic event,		20a. Method of Disposition			Place of Dispos crematory or ot		of ceme	etery,		Date	20c. Loc	cation - Cit	y or Town, State			
imore, MD 2121 Pages I and 2 should be fi neut of Health and Mental I ant: If item 27 is marked or other traumatic event,		1 X Burial 2 Cremation		IUIII State I	l Saint		ie C	'em	11/2	9/200	7 Ch	namp,	MD.			
timen trant		4 Donation 5 Other St				Name and A				all Fi				-		
Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Ment Important: If item 27 is markingury or other traumatic even		21. Signature of Full dai Service	Licensp	00		12 NW					wie, M		20715			
		23a. Part I. Enter the disease, or	complications that	caused the death	Do not enter t	the mode of	dving. s	uch as ca	ardiac or i				Approximate Inte	erval		
Physician Medical		failure. List only one cause	on each line.				,						Between Onset Death	and		
aminer	1	Immediate Cause (Final disease		tyline in		on										
h		or condition resulting in death)	Due to (or as	a consequence o	f):											
		Sequentially list conditions,	b	a consequence o	f).			_	_	_			- 			
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	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	of):			_					-			
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87 tifica ng pl	ľ,	23b. Was decedent pregnant in t past 12 months?	ne 1 Live		2 F	etal death	3	Ectopic	pregnan	су	M	lonth	Day Year	r		
x 6 h cer tendi	icia			nant at time of de		ther (Spec	ify)				İ					
that the death certiff that be attending detached for use as if	Physicia			nown						las ni		11		- 2		
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ords, w requir	ete									24a. Wa	as an copsy		re autopsy findings ava r to completion of cause			
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Vital Recor hysician: The law 1 this certificate has I I director, page 2 sh	Completed						C Disease	-f Da ath	(Chaple o	1 Yes	3 Z NO	1 🗸	ries 2 iv			
tal certif	Be	25. Was case referred to medical examiner?	Hospital:				- 1/	of Death Other			Desident		Other: Scene			
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ion tend eath.	atio			11/24/200				es 2 X		unk				-		
IVISIOI or Attene after death Director: d in by the	Ę	3 Suicide 6 X Cou	200 Die	ace of Injury - At h	nome, farm, stre	eet, factory,	office bu	uilding, et	tc.	28f. Location or Town	(Street and . State)	d Number o	or Rural Route Number	, City		
Divital of urs all urs all []	Certification:	4 Homicide dete	ermined (Specific	found	at h <u>ome</u>					10009 1	vorre11	Ave.	Glenn Dale, M	D		
Hosp 24 ho Fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to									s stated.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Exa	aminer:On the basi	s of examination a	and/or investig	ation, in my	opinion,	death oc	curred at	the time, da	ite and place	e, and due	to the cause(s)			
To To cor	Me	29b. Signature and title of certifi		stated.		290	. License	e number			29d. Da	ate signed	(Month, Day, Year)			
	_	0	11	/			O.C.N	И.E.			Nove	mber 25	5, 2007			
			MIL		- 02s\						1					
		30. Name and address of perso	n who completed ca puty Chief Med			enn Stree	et Balt	imore	MD 21	201						
				Registrar's Signat		01186	- Dail									
S Regis	tate		R 2007	Registrar's Signal	J. An	West										
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		For State Registrar	State of Marylai		rtificate of			leg. No. 2	7 38015			
Physicia	an	Decedent's Name (First, Middle, Larry Larry	•				2. Date of Dea Month	Day Ye				
/Medic	al⇒	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	November	4c. County of D	01			
Examin	er 6	Washington County			Hagerst			Washin	gton			
Funeral Director		219-44-3462		. last birthday 62 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 1	7, Year) 9. 7, 1945 M.	Birthplace (State or Foreign Country) aryland			
aryland show d at	_	Usual Residence of Decedent 10a. State 10b. County Maryland Washingt		ity, Town or L lugansv					10d. Inside City Limits 1 ☐ Yes 2 No			
the Ma 28a-f s	ecto	10e. Street and Number			10f. Zip Code			10g. Citizen of What	- 17			
ath with t	Funeral Director	18030 Edith Aven			21	1767		U.S.A.				
IIS 8	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- po Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. white			
72 hc "natul	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retired	nation during most of work	16b. Kind of Busine	ess/Industry				
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Pages 1 Iment of Hatant; If iter		1⊠Buria! 2□Cremation 3□ 4□Donation 5□Other (<i>Specit</i>	rinemoval from State	Rose Hi	osition (Name of ematory or other place 11 Cemete	ery 21	,2007	Hagerstow	n, Maryland			
permit. Depart Import any inj once.		21. Signature of Funeral Service Licer	D.		2. Name and Addre	•		h Funeral	Home Maryland 2174			
22500		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea						Approximate Interval Between			
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ASYS	70L	E		,		Interval Between Onset and Death			
/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	441	10 TEN	CIANI					
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tificate be executed ig physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conse	quence of):	BEPA	PNEA						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/IV	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 ☐Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc □ Other (spec <i>ify)</i> _	у		23d. Date of Month	delivery Day Year			
uires that signed by d be deta	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 □Unknown			
s beer s beer	lete	ACUTARAN	AL 60 A1	1017	A		24a. Was a	an 24b. Were	e autopsy findings available to completion of cause of			
n: The lav ficate has or, page 2 :	Completed	MONBID OR E	S174, T	4PB	IV DI	ABEYE	1□ Yes	med? deat 2☑No 1☐\	h?			
ysicla is cert	To Be	examiner?	Hospital: 1 Inpatient 2	BR/Outpatie	nt 3 DOA Oth	or:	th <i>(Check only or</i> ome 5 ☐ Resid	ne <i>)</i> lence 6 ∐Other <i>(</i> 5	Specify)			
ng Phy ter thi	L i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time				ow injury occurred				
tendir eath. tor: Ai	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1□	Yes 2□No						
tal or At rs after d ai Direct ed in by	Certification:	4 Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, si ify)	reet, factory, office		28f. Location (S City or Tow	itreet and Number o n, State)	r Rural Route Number,			
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical		ysician: To the best of my kn niner: On the basis of examir and manner stated.									
To th	Ĭ	29b. Signature and title of certifier	1 1.	_	29c. Licens	se number	2	29d. Date signed (M	lonth, Day, Year)			
		30, Name and address of person, who	completed cause of death (Ite	m 23a) (Tyne	DOC	6339	16	11/18]	07			
4-5		Dr. Mercy Ku	rapaty, 25	I E. A	ntietam	St., Hag	erstown	, MD	21740			
Sta Registra		31. Date filed (Month, Day, Year) NOV 19 2	32. Registrar's Sign	ature	yearly .							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

6

obert Jackson, .	1.	State of Maryland / Departi For State Certif	inent of Health and t		Reg. No.	A ***
Physicia		e qistrar . Decedent's Name (First, Middle,Last)		2. Date of De	ath Z U	3 Time of Death 0005 hrs
ledical Examin		ROBERT TROY JACKSON, JR	4b. City, Town, or Loc	Novembe	er 6, 2007 4c. County of Death	0005 1115
*		a. Facility Name (if not institution, give street and number) Suburban Hospital	Bethesda	, and 10, 2000	Montgomery	
Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. last $213-13-7259$ $1 X_{M}$ $2 F$ 21	birthday) If Under 1 Year Months Days	If Under 24Hrs. 8. Date of E Hours Min. Oct.	6, 1986 Cou	
any	_	Jsual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	-		10d. Inside City Limits
Š .tl		167	Germantown			1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	Oe. Street and Number	10f. Zip Code		10g. Citizen of What Cour	ntry?
h the N 23a or		18511 Owl Run Way		874 nic Origin? (Specify Yes or N	U.S.A.	can Indian, Black,
ath wit items	۵I	11. Marital Status 1 X Never Married 2 Married 4. Armed Forces?	If Yes, specify Cuban, N	Mexican, Puerto Rican, etc.)	White, etc.	our main, black,
after de	by Fun	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2X No s		Specify: Blac	
hours a	ted b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation during most of working life. D 	n (Give kind of work done O NOT use retired)	16b. Kind of Business/	Industry
215-0036 be filed within 72 hours after death with the Maryland nital Hygione. rked other than "natural", or items 23a or 28a-f sheen, the Medical Examiner must be notified at once	Completed	12th	None			
MD 21215-0036 42 should be filed within 7 tth and Mental Hygiene. n 27 is marked other than marke event, the Medics		17. Father's Name (First, Middle, Last) Robert T. Jackson, Sr	18	Mother's Name (First, Middle	e, Maiden Surname) aine Cleme	nta
21215 uld be file Mental H marked o	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street a			
e, MD 2 Land 2 shou Health and I item 27 is in		Sheila E. Clements (Mother) 18511 Owl 1	Run Way, Ge	rmantown,M	D 20874
tra lea an			ace of Disposition (Name of ceme ematory or other place)		20c. Location - City or	
Baltimore, permit. Pages I al Department of He Important: If ite	Ц	4 Donation 5 Other Specify:	1 Souls Cem	11/13/0 SNOWDE	7 Germant	
Baltimore permit. Pages 1 Department of I Important: If injury or other		21. Inature of Funeral Service Deensee	246 N. Was	shington St	,Rockville	
Physician		23a. Part I. Enter the disease, of complications that caused the digith. Efailure. List only one cause on each line.	Do not enter the mode of dying, su	uch as cardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and
/Medical / raminer	1	Immediate Cause (Final disease a Sharp Force Injuries				Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
B of nuted	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED AMENDED				
3760, ificate be g physici	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnat 1 Live birth	2 Fetal death 3	Ectopic pregnancy	23d. Date of delive Month	ry Day Year
Box 6876 death certificate the attending phy ed for use as the b	sicia	past 12 months? 4 Pregnant at time of deat				
b. Bc the dea by the a	Phys	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause giv	ven in Part I. 23e. Di	d tobacco use contribute to	o the cause of death?
Division of Vital Records, P.O. But no Attending Physician: The law requires that the defeath. al Director: After this certificate has been signed by the lied in by the funeral director, page 2 should be detached it	d by			1	Yes 2 ✓ No 3 Pro	
rds, requir	lete				utopsy prior to	autopsy findings available completion of cause of
Reco	Completed			1 ✓ Ye	erformed? death?	
tal F cian: Certific ector, 1	Be	25. Was case referred to medical examiner? Hospital: 4 lengtion 2 2 1		of Death (Check only one) Other: Nursing Home 5	Residence 6 Oth	er:
of Vi Physic Perthis	-T	1 Ves 2 No Impater 2 Ver 27 Manner of Death 28a, Date of Injury		at Work? 28d. Descri	be how injury occurred	G1.
OD C ending sath. or: Af the fun	Certification:	5 Penaing	1831 hrs 1 76	es 2 V No	tabbed and cut	
ivisi or Att after de Direct	tifica	3 Suicide 6 Could not be 28e. Place of Injury - At hor	me, farm, street, factory, office bu	or Tou	on (Street and Number or F m, State) Road @ Russell Avent	
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been seem tompletely filled in by the funeral director, page 2 should	Cer	4 V Homicide determined (Specify) Sidewalk 29a. Certifier 1 Certifying Physician: To the best of my knowledg	o death occurred at the time dat			
the II thin 24 the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.	d/or investigation, in my opinion,	death occurred at the time, d	late and place, and due to	the cause(s)
To To	Me	29b. Signature and title of certifier	29c. License		29d. Date signed (M	
3		Carol Hallar	O.C.N	1.⊨.	November 6, 20	
		30. Name and address of person who completed cause of death (Item Carol Allan, MD Assistant Medical Examiner	^{23a)} 111 Penn Street, Baltimo	ore, MD 21201		
	tate	31. Date filed (Month, Day Year) 32 Registrar's Signatu				
Regis	trar	NOV 13 2007 Beaux D	THE PERSON NAMED IN COLUMN TO SERVICE OF THE PERSON NAMED IN COLUMN TO SERVICE			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. 8, Day 200 7 ear Frances Marjory Jeffcoat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Nursing Center Frederick Walkersville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 17, 1924 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Months 577-30-2742 1 M 2 € F 83 Country) D• Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Frederick Walkersville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 2101 Fairland Ave. USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Vidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry federal Elementary/Secondary (0-12) College (1-4or 5+) gov't. secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabel C. Finch John J. Chisolm II 19a. Informant's Name/Relationship (Type. Print)Sister-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Chisolm (in-law) 1425 Jupiter Rd., Rapid City, S. D. 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Dorial 2 Oremation 3 Removal from State Smithsburg Crematory11/12/07Smithsburg, MD 4 Donation 5 DOther (Specify) 21. Signature of Fu eral service L Donard dd B. Thompson Funeral Home P. O. Box 18, Middletown, MD 21769 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Imme liale Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

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'I Hygiene.
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Baltimore, Maryland 21215-0036

burial-transit physician the as attending plant for use as signed by the a d be detached f cate has been sig , page 2 should b

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

certificate has this

Physician/Medical funeral director After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the

	State
Reg	istrar

9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifies

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** KOO 7:25 A JOHN Κ. NOV. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 □ F Yrs 201-28-1375 89 Director NOV. 9, 1918 CHINA Usual Residence of Decedent show 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shor idical Examiner must be notified at 1 to Yes 2 □ No MD. MONTGOMERY **BETHESDA** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 Funeral 5310 DANBURY RD U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after dal Hygiene.
other than "natural", or iten 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: 3 Widowed 4 Divorced ASIAN Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ MEDICAL SCIENTIST PHARMACEUTICAL CO. Pages 1 and 2 should be filed and the solution of Health and Mental Hyginnt: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျ SIEN-TEH K00 ZE-YING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trau once. HOWARD YAN/NEPHEW 5310 DANBURY RD., BETHESDA, MD. 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) PARKLAWN CEMETERY 11-18-2007 | ROCKVILLE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FUNGAL PERITONITIS 1 MONTH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate occus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trar Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 💢 No 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1

∏ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37891 NOV. 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJVANSHI, M.D. AMIT 121 CONGRESSIONAL LN. #409, ROCKVILLE, MD. 20852

State Registrar 31. Date filed (Month, Day, Year) 32. NOV 13 2007



Kac, John

	1 - State Registrar	Cei	rtificate	of D	eath		Reg. No. 2007 38010						
Physician /Medical	Decedent's Name (First, Middle ROBERT WILL		т						2. Date of D NOVEME), 2ď0	7 1	0:45 A M
Examiner	4a. Facility Name (If not institution FREDERICK MEM				4b. City, Tov F'RE		ocation o	of Death		4c. (County of D FRED	eath ERIC	K
Funeral Director	5. Social Security Number 212–38–6552	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Y Months D		If Under Hours	24 Hrs. Min.	8. Date of E (Month, I Oct. 2	Birth Day, Year) 27, 19		Birthplace <i>Country)</i> Mary	e (State or Foreign land
e Maryland a-f show tifled at	Usual Residence of Decedent 10a. State 10b. County Maryland Free	derick		, Town or Lo									Inside City Limits 1 ☐ Yes 2 ☑ No
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10e. Street and Number 23 Main Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Deceden (Specify only higher Elementary/Secondary (0-12)	Armed F 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ad 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Korean s Education t grade completed) College (1-4or 5+) 16a. Decer			No No ccupat one du etired)	Specify: tion uring mos	st of workin	ncify Yes or N Rican, etc.)	Yes or No- n, etc.) United 14. Race - Am Black, Whi Specify: 16b. Kind of Business Departmen			ndian, ite
Maryland 21 nd 2 should be filed w that and Mental Hygies 27 is marked other it reaumatic event, the	12 17. Father's Name (First, Middle, Thomas Kight		st)				Lo1a	er's Name ı Harj	per	of Energy fle, Maiden Surname)			
Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once.	19a. Informant's Name/Relations Dorothy D. Kig 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Juneral Service	ain Str sition (Name of matery or other n Memon 2. Name and A cauffer	eet rplace, cial ddress Fu	, Wa	alkersville, Maryland 21793 Date 11/16/2007 ardens Prederick, Maryland al Home P. A.								
8760, ate be executed Thysician and The burial-transit The burial-transit Tical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any Laung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to c. Due to	caused the death each line. (or as a consequence of the consequence o	uence of):	Fail emb	n C	, such as	s cardiac o	ke, Fr	ederi	ck, M	Ap	and 21702 pproximate lerval Between set and Death Days Days Days weeks
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome pf pregna birth 2 Feta Inant at time of d	Ideath 3	⊒Ectopic pregi ⊒ Other <i>(speci</i>					- 2	23d. Date of Month	delivery Da	y Year
	Part to Other significant condition	ons contributing to d	Hyper		1	e giver	n in Part	I. 	1 [24a. Wa au pe	Yes 2	No 3 24b. Wern prior deat	Probable autopsyr to comple	findings available etion of cause of
Division or Vital Records, To the Hospital or Attending Physician: The law requires to within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pendir investigned Government of the could determ the country of the	Hospital: 12 28a. Date (Mo. gation not be lipped 28e. Place		ER/Outpatier 28b. Time of Injury ome, farm, str	f 28c	Other Injury Work? 1 Y	r: 4□ N	ursing Hor	1 Yes 1 (Check onl) 1 Second on the sec	y one) esidence (e how injur	6 □Other (3	Specify)	oute Number,
To the Hospital of within 24 hours af To the Funeral D completely filled in Medical Cer	(Check only 2 Medical one)				vestigation, in	my op				ne, date and		due to th	e cause(s)
\$+1 \	29b. Signature and title of certifie Mand 30. Name and address of person	who completed cau		_	Print)	DE	,40			11/	10/0	27	,, roar/
State Registrar	31. Date filed (Month, Day, Year)	PANDE 32.	Registrar's Signa	D: 4(90 West	7t	h St	reet	, Fred	lerick	: MD 2	1/01	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

			1 - State Registrar	Certificate of Death Reg. No. 2007 38020
	Physici	_	1. Decedent's Name (<i>First, Middle, Last)</i> Lidia Antonia Liriano	2. Date of Death North Day November 11, 2007 5:55 a. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park 4c. County of Death Montgomery
ţ	Funeral Director		5. Social Security Number 216-57-3812 6. Sex 1 □ M 2 ☑ F 82 YI	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Set 1925 Dominican Republ
	Maryland a-f show ffied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Maryland Prince George's Hya	or Location 10d. Inside City Limits attsville 1 ⊠Yes 2 □ No
	th with the 23a or 28a st be not	al Director	10e. Street and Number 6621 23rd Place	10f. Zip Code 10g. Citizen of What Country? 20782 Dominican Republic
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mertal Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1☑ Yes 2☐ No Specify: Dominican Specify: Hispanic
Maryland 21215-0036	within 72 ho iene. than "natui the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry Own Home
land 2	uld be filed fental Hyg rked other tic event, i	To Be C	17. Father's Name (First, Middle, Last) Francisco A. Liriano	18. Mother's Name (First, Middle, Maiden Surname) Enriqueta Liriano
	1 and 2 should I Health and Men em 27 Is marker other traumatic		Minerva Amezquita-Daughter 662	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 23rd Place, Hyattsville, MD 20782
Baltimore,	Pages 1: ment of He ant; If Iten ury or oth		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Disposition (Name of control of place) io de Salcedo Date 200. Location - City or Town, State Salcedo, Dominican Repub.
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781
do:	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
0	/Medical Examiner		Due to (or as a consequence of ANTERIOS C	LE ROTI C CARDIO VASCULAD DISPASSE
	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	TENSION
68760,	ificate be executed g physician and as the burial-transit	edical Ex	Due to (or as a consequence of):
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and agge 2 should be detached for use as the bural-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 23d. Date of delivery Month Day Year
ds, P	uires that signed b Id be deta		Part II. Other significant conditions contributing to death but not resulting in to the CARLAL FIBRIT	the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Records, P	he law req e has beer ige 2 shou	Completed by	2 DIABETES MELLITO	24a. Was an autopsy performed? performed? death?
Vita	sician: T certificat rector, pa	Be	25. Was case referred to medical examiner? 1 Yes 20 No Hospital: 1 inpatient 2 NER/Outp	26. Place of Death (Check only one)
Division or	Attending Physician: The laving death. rector: After this certificate has by the funeral director, page 2	tion: To	27. Manner of Death 28a. Date of Injury 28b. Tin (Month, Day Year) Inj	4 Nursing Home 5 Residence 6 Other (Specify)
Divisi	= E = E	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	m, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C		death occurred at the time, date and place, and due to the cause(s) and manner as stated. I/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
)	Total Within	Me	29b. Signature and title of certifier	MMD29c. License number 593 Povem Ber 11, 2007
_	4		30. Name and address of person who completed cause of death (liter 23a) (T	VPONID,) 3331 - TOLEDO TERRACE HYATTSVILLE, MD 20782
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 3 2007 NOV 1 3 2007 NOV 1 3 2007	de la companya della

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 38021 Certificate of Death 3. Time of Death 2. Date of Death Day 7 1. Decedent's Name (First, Middle, Last) Month 2:50R **Physician** Reynolds Lemmon November 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 91 Yrs. 8. Date of Birth (Month, Day, Year) 7/25/16 Birthplace
 Country) (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🗙 F 129-07-6883 Brooklyn, NY Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at MD 1 XYes 2 No Montgomery Gaithersburg Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 401 Russell Ave. #406 20877 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TXYes 2 No. If Yes, Give 1943–1946 Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael T. Reynolds Theresa Quinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Russell Ave. #406 Gaithersburg, MD 20877 Kelley B. Lemmon Jr/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 11/15/07 Injury (Cremation Center Chantilly, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Murphy Funeral Home 4510 Wilson Blvd. Arlington, VA C. Mascur 22203 Approximate Interval Between Onset and Death 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fachere to Thrive Immediate Cause (Final Luceks **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner ore seles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown detached 9 Unknown Part JJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed adenon 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No 13 hain 25. W s ca e referred to edical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Vital 9 or Attending after death the Funeral Director: npletely filled in by the To the Hospital within 24 hours a completely ပ္

The law requires that the death certificate be executed

Records, P.O. Box 68760,

and

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) NOV 1 3 2007

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. ROBERT BIRSC HBACH, NA 32. Registrar's Signature

M. Robert Businleadurs

Registrar

004115

201 RUSSELL AVENUE CAITHERSBURG, NID 20871

State of Maryland / Department of Health and Mental Hygiene 2007

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER Day 3, 2007 **Physician** 8:43A M Marlene Mildred /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 28, 1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Mary land 1 □ M 2XX 69 Director 212-38-8501 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23a r death Funeral 21795 USA <u>16135 Cloverton Lane</u> 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify. ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 Is marked other than ' other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Mildred Omar Meyers, Sr. Harry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1795 19a. Informant's Name/Relationship (Type. Print) Charles W. Litten - Husban¢ 16135 Cloverton Lane Williamsport, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or oth Greenlawn Mem. Park Nov.16,2007|Williamsport, MD 4 Donation 5 Dother (Specify) 21. Sign were of Funeral Service एडे अक्रा भिक्षां कर प्राप्ति कर मार्थ प्राप्ति प्राप्ति में प्राप्ति 425 S. Conococheague St. Williamsport, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INTRACEREBRAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): OF CORONARY ARTERY DISEASE Examiner COMPLICATIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 27 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ➤ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 OSLER DRIVE. 7601 LOW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV agrant that

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1:50 рм November 9, 2007 Lutchman /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 812 University Blvd. East, Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months MM 2□F 213-04-4339 78 April 6, 1929 Trinidad & Tobago Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County ms 23a or 28a-f show must be notified at 1 □Yes ♥ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 812 University Blvd. East, #3 20903 Trinidad & Tobago death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural', or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Asian Indian Specify: þ 3€Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Construction Foreman 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth Be Harris Lutchman Theresa Mathurasingh ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14112 Rectory Lane, Upper Marlboro, MD 20772 Maureen Cuthbert/Daughter if item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Nov. 13, 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any Injury or Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 21. Signatur of Funeral Service Licensee W. Silver Spring, MD 20901 500 University Blvd, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Prostate Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical certificate the as attending p for use as IF FEMALE 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth 2 Fetal death Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9□Unknown the 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 ☐ Yes 2 ☐ No certificate 2 1X No. 1☐ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 \(\text{Nursing Home} \) 532 Residence 6 \(\text{Other} \) (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No 1 Inpatient 2 this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After t al or Attending P after death. I Director: After i Certification: (Month, Day Year) Division Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide thin 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within ? 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D08754 Nov. 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, #205, Greenbelt, MD 20770 Thomas Bensinger, MD egistrar's Signature 31. Date filed (Month, Day, Year) State 13 NOV 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 10 2007 11:30 P M Bernice Lee Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3403 Hummingbird Court Ijamsville Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2⊠F Months Days Hours 58 Director 215-54-8264 Nov. 21, 1948 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notifled at 1 ☐ Yes 2 No Director Ijamsville Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21754 United States 3403 Hummingbird Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 □ Never Married 25 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. ģ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Senior Policy Analyst U.S. Government marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Innt: If item 27 Is marked of Molly Kogan ပ Myron Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Lee / Husband 3403 Hummingbird Court Ijamsville, Maryland 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State November 12, 2007 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig ature o Fynera Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 5 Other (specify) P.O. the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, SMAIL CELL LUNG CANCER 1 □ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 20 No 1 TYes P After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Attending (Month, Day Year) Injury 1/ Natural 5 Pending 1 □ Yes 2 □ No Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital or To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 24 the 29c. License number 29b. Signature and Atle of certifier 29d. Date signed (Month, Day, Year) D31761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOI W. SEVENTH ST. FREDERICK MO BRIAN M. OCONNOR MD

DHMH 17 Rev 1/200

Registrar

31. Date filed (Month, Day, Year)

32. Registra 's Signature

Blown

2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MA CO: 10 Joseph Latteri ,09,2007 NOVEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner TMORE None If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) ial Security Number 6. Sex **Funeral** Hours Months Days 1137M 217 F New York Sept 3, 1918 089 28 3775 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐ Yes 2 ☐ No r 28a-f sh notified Director MD Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be i 10739 Bridlerein Terrace 21044 United States by Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 1/2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bakery 12 Owner Is marked other aumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Di Lapi Benedetto Latteri ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any Injury or other trauonce. 30 Edward Court Basking Ridge, NJ 07920 Vincent J. Latteri/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11-12-2007 Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Pk 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 ollis 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HOURS RIGHT LUNG CONSOLIPATION resulting in death) /Medical Due to (or as a consequence of): Examiner AINOMUZNA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed HEART FAILURS DAYS CONGESTIVE Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Injury 5 Pending investigation 1 □ Natural 2 □ Accident 1 ☐ Yes 2 ☐ No after death in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P9150 amu alitamieni mo MOVEMBER,09,200 60 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) aton Ave. Baltimore, Maryland 900 (32. Registrar's Signature State Registrar

			For State Registrar	State of Maryla		ertment of He etificate of D			giene Reg. No.	007	38026
6 -	Jei es		Decedent's Name (First, Middle, Las	t)			1 . 1	2. Date of Dea		Year	3. Time of Death
	Physicia Medic		TIMOTHY	<u> </u>	^	NESSIN	HN	NOVEMBER	2 17	2007	10:00 AM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or		1		inty of Deatl	
7			THE JOHNS HOPLINS 5. Social Security Number 6. Se		s. last birthday)	BALTIMO If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birtl	hplace (State or Foreign
	Funeral Director			©M 2□F 44	Yrs.	Months Days	Hours Min.	Feb 27		Co	untry)
	70		Usual Residence of Decedent	1400	Dir. Town and a						10d. Inside City Limits
	anylar show	'n	10a. State 10b. County		City, Town or Lo	cation					1 ☐ Yes 2 ☑ No
	the M 28a-f notifie	Director	PA York 10e. Street and Number	10	rk	10f. Zip Code			10g. Citizen	of What Co	untry?
	3a or		2729 Heather Drive	.		1740	2		U.S		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of His f Yes, specify Cuba		pecify Yes or No		Race - Amer Black, White	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2万 No	Specify:	Triodii, 6to.)			hite
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<u>a</u> ŭ	ld be ental ked o Ic eve	To Be	Charles C. Messi				Kay L	. Keese	У		
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailin	ng Address (Street a	 			wn, State, 2	Zip Code)
	and 2 salth a 127 is er tra		Stephanie H. Mess			Heather D	r. Yo	rk, PA	1740		
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 🔀		 Place of Dispo cemetery, crer 	sition (Name of matory or other plac	e)	Date	20c. Locati	on - City or	Town, State
<u>=</u>	t. Pag tment tant: jury o		4 Donation 5 Dother (Specify	() W		se Cremat		/20/07	Yo	rk, P	
Bal	permil Depar Impor any ir once.		21. Signature of Funeral Service Licen	Glochtz		2. Name and Addres urg Funer		Inc.	134 W.	Broa	17356 dway Red Lion
199	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the de one fause on each line.	eath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a lons	equence of):	ogenou	15/11.	.kam.	a		1 11/6
		er	Sequentially list conditions if any, leading to immediate	b. Due to (or as a cons	equence of):	genou	rs Lei	cheril	-(5 years
}	ficate be executed physician and s the burlat-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
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Θ	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome pf pre	gnancy				23d	. Date of del	livery
P.O. Box	es that the death certiff igned by the attending be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Who 9 ☐ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)				Month	Day Year
٦.	that the bound of the position	y Ph	Part II. Other significant conditions of	contributing to death but not i	resulting in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco use	contribute to	o the cause of death?
rds	quires n sigr uld be	q pe						1 🗆	Yes 2	6 3□P	robably 4 Unknown
Division or Vital Records,	The law requires that the death certifithe has been signed by the attending tage 2 should be detached for use as	Completed by						24a. Was auto perfo 1□ Yes		24b. Were and prior to death?	utopsy findings available completion of cause of
ital	lan: rtifica	Be C	25. Was case referred to medical examiner?				26. Place of Dea				
<u>×</u>	Physician: r this certific ral director,	To E	1 ☐ Yes 2 No	7	ER/Outpatier		4 🗀 Nursing F	lome 5 ☐ Resi			ecify)
n c	ng fte	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Worl	y at k? Yes 2 □ No	28d. Describe	how injury o	ccurred	
isi	Attending r death. ector: After	icat	2 Accident investigation 3 Suicide 6 Could not b		t home, farm, str		163 2 10	28f. Location (Street and N	lumber or R	ural Route Number,
<u>></u>	after after Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)			City or To	wn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) CertifyIng Ph	nysician: To the best of my miner: On the basis of exame and manner stated.	knowledge, deat hination and/or in	th occurred at the tire	me, date and place opinion, death occ	e, and due to the urred at the time	cause(s) ar , date and pl	d manner a ace, and du	s stated. e to the cause(s)
	To the To the To the Compl	Me	29b. Signature and title of certifier		0	29c. Licens			29d. Date s	igned (Mon	th, Day, Year)
)			MEI , MEI	DICAL DOCT	OK	RES	5-000		JOVEMB	ER 1	7,2007
	20		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)					
			31. Date filed (Month Day-Year)	JOHNS HOPKINS	mature I	74460 N	PATH WOL	LTE STRE	CT, BAL	TIMORE	, MAKYLAND 21287
	Sta Regist	nte rar	31. Date filed (Month, Day, Year) NOV 2 8 20	107 Marie .	15 April	14/23					
			125 A M C	A -							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** NOV. 2007 MARY MARGARET MCGUIGAN 12:31PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11080 WEYMOUTH COURT #324 CHARLES WALDORF 8. Date of Birth (Month, Day, Year)
DEC 20, 1927 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🗓 F Months Days Director 79 218-26-8965 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modcal Examiner must be notified at 10a, State 10b. County 1 ☐ Yes 2 No Director MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once. 11080 WEYMOUTH COURT #324 20603 S. Funeral À. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 2 31 XWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES ASSOCIATE DEPARTMENT STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN A. LYON BERTHA G. IRWIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ATENA PAUL / DAUGHTER P.O.BOX 2041 LUSBY, MARYLAND 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State NOV. 26, 4 ☐ Donation 5 ☐ Other (Specify) ST.PETER'S CEM. WALDORF, MARYLAND 2007 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licenses 5635 WASHINGTON AVE. LA PLATA, 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HROULE /Medicai Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence or) Examine The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9□Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 2007

KAUFMAN.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070 OLD LINE CENTRE WALDORF,

MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 11-10-2007 CASSAUNDRA M MARINER 2055 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Days Funeral 1 ☐ M 2 🗙 F 213-02-7335 12-15-1965 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ns 23a or 28a-f show must be notified at 1 TYes 2 □ No DC Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 3298 Ft Lincoln Drive 20018 NE Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene. Assistant and Mental Hygiene. Assist I fitem 27 is marked other than "natural", or items 23 anis: I fitem 27 is marked other than "natural", or other traumatic event, the Medical Examiner must rry or other traumatic event, the Medical Examiner must by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Nidowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Assistant Manager/Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Martin Delores Woodland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10404 Terraco Dr. Cheltenham MD 20623 Harry Martin /Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Metropolitan Crematory 11-14-2007 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Home of Funeral Service License Sign 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perforn certificate To Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 28a. Date of Injury Certification: 27. Manner of Death 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

mes

29b. Signature and title of certified



releted cause of death (Item,23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

		•	For State Registrar	State of N	Maryland / I	Departme <i>Certifica</i>			nd Men	ntal Hygie Rag.	ZUUI	38029
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, WLLIAM 4a. Facility Name (If not institution,	MARC		4b. Ci	y, Town, or	Location of	1	Date of Death Month	Year Year Zoo 7	
	Funeral Director	CI	Lorien Nursing	Home	Age (In yrs. last bi	rthday) If Und	umbia er1 Year s Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Ye	Howard	thplace (State or Foreign ountry)
	p		Usual Residence of Decedent 10a. State 10b. County Florida Brevan	· A	10c. City, Tow	m or Location	1			1/1920	Man	10d. Inside City Limits 1 Yes 2 □ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23s or 28s-f show event, Ire Medical Examinat must be notified at	Funeral Director	10e. Street and Number 444 Beach Park 11. Marital Status				Zip Code		32920 jin? (Specify		Citizen of What C USA 14. Race - Am	erican Indian,
-0036	Phours after of turns!, or item	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent	If Yes, Give Year or Dates	1950 – 1953	1 ☐ Yes	2 No	Specify:			Specify: Kind of Business	White
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Marylan	permit. Pages 1 and 2 should be obpartment of Health and Mental Importent: If Item 27 is marked o any injury or other treumatic everage.	To Be	William T. Mar 19a. Informant's Name/Relationsh Jeanne Dezbor/S	p (Type, Print)		-		and Number	r or Rural Ro		ty or Town, State, eral, FL	
Baltimore,	Pages 1 and the ment of Healt tent. If Item 2 jury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	ecify)	20b. Place o	of Disposition (I ery, crematory of Lincoln	lame of r other place Cemet	ery 1	Date 11/13/	2007 Br	entwood,	r Town, State Maryland
Ball	Departition Departition Important Im		21. Signature of Fureral Service L 23a. Part 1. Enter the disease, or shock, or heart failure. List of	Mule complications that caus	ed the death. Do	3401	Blader	nsburg	g Rđ.,	Brentw	Funeral	Approximate Interval Between
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P.O. Box 6	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	h 3⊟Ectopie 5⊡ Other	pregnancy (specify)				23d. Date of do Month	elivery Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	ns contributing to death	but not resulting	in the underlyin	g cause give	en in Part I.		1 ☐ Yes	2 No 3 F	to the cause of death? Probably 4 Tonknown
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	를 을 을 듣	Medicai C		p Physician: To the be examinar: On the basis and manner								
)	£ 10 0	4	29b. Signature and title of certifier 30. Name and address of person of	who completed cause of	of death (Item 23a)	(Type, Print)	D (o number	5315	290	10V 9	2007 0 MD
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Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or Lo	ocation of Death		40	C. County of		
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pu *		10a. State 10b. County		10c. City.	Town or Lo	cation						10d	Inside City Limits
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d b ents	.0	Ronald Charles M	yers, Sr.					Irene	e Dougl	as			
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and alth 27 er tu		Irene Stuller -	mother					Valley I)r., Ha	gers	town,	Md.	21742
oth He		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name natory or othe	of		Date	20c. L	.ocation - Cit	ty or Town	ı, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 □ Cremation 3 □		1				1	107	Hac	·ozato:	\	forest and
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		shock, or heart failure. List only	one cause on each lin	ne.								l In	iterval Between
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spit nour ners			hysician: To the best						and due to th	e cause((s) and manr	ner as stat	ed.
To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical		miner: On the basis o and manner sta	f examinatio									
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No.	Σ	29b. Signature and title of certifier	2/2			29c. L	icense n				ate signed (Month, Da	ıy, rear)
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11		30. Name and address of person who			За) (Туре,	Print)				2		_	
4-5		DONALD K	1sence		27	Some	24 (steens	57 1	sho.	inov 6	MA	2/20/
Sta	ate	31. Date filed (Month Day Year)	32. Registr	ar's Signatu	re	1 .							
		INITIAL C	#18555 Mg.		200 3	W							

Examiner Division or Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar physician the as detached s been signed by the should be detached After this 24 hours after death e Funeral Director: filled in by the Medical within 24

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at an once.

Physician

/Medical

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending investigatio		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death or miner: On the basis of examination and/or investand manner stated.	ccurred at the time, date and place tigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	2 11	29c. License number	29d. Date signed (Month, Day, Year)
+ Lover	Puthumans 4	D59524	November 9,2007
30. Name and address of person who	completed cause of death (Item 23a) (Type, Prin	nt)	

State Registrar 31. Date filed (Month, Day, Year)

13 2007



			1 _ State	State of Ma	aryland / Depa Cea	artment of H <i>rtificate of L</i>			2001	38032
			Registrar 1. Decedent's Name (First, Middle,	Last)		incate or E		Reg. 2. Date of Death		3. Time of Death
	Physici		Doris M. Maie:	r			1	Month November	9, 2007	6:30 a M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of Oeath	
			3160 Gracefield	-			Spring		Prince Geo	
	Funeral Director		5. Social Security Number 577-24-8871	5. Sex 7. Aga 1 ☐ M 2√∑F	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye June 28,	9. Birthp 20ur 1922 Wash	lace (State or Foreign htry) ington, DC
	laryland ahow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits 1 ☐ Yes 24 No
	8a-f.s	Director		e George's	Silver S					
	th with the		10e. Street and Number 3160 Gracefield	d Road, Apt	. 2220	10f. Zip Code	20904	10g.	Citizen of What Cour USA	ntry?
5-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23s or 28s-f show other traumatic avant, its Medical Examiner must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrier 3 덫 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 Tes 2 50 If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 12 No	spanic Origin? (Spen n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh:	
20	72 ho natur	ted	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation	16	o. Kind of Business/In	dustry
2121	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) life.	Owner	luring most of workin)	9	Child Care	e Center
	2 should be filed with and Mental Hygiene Is marked other tha aumatic avant, I.s.	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's Name	(First, Middle, Mai	den Sumame)	
<u>S</u>	should be nd Mental marked o	To	John W. Murphy				Florence	e May Ber	nett	·
Maryland	2 sho	9 3	19a. Informant's Name/Relationship	o (Type, Print)	19b. Mailir	ng Address (Street a	ind Number or Rura	Route Number, C	ity or Town, State, Zip	Code)
	ges 1 end of Health If Item 27 or other tr		Cecilia M. Gilcl 20a. Method of Disposition	nrest/Daugh	ter 60 Mc		The second second		MA 0212	
mor			1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		MD Veteral	natory or other place n's Cemete	erv Nov.	16, Fli	ntstone,	- 10
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Li		Rocky f		s at Facility in s	0/		
ī	202 4 4		23a. Part1. Exter the disease, or or	omplications that caused	6				er Spring	MD 20901 Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each lin	ne.	monia	,, 00011 00 001 0100 01	,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		re to t	hrive		
2	pe tis	iner	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):		16 10 1	11110		
ν (C	execution and ial-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of	it loss			-	
68760,	ficate be executed physicien and s the burial-transit	edicai		d						
Box 6	eath certific ettending p for use as	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	erv
P.O. Bo	The law requires that the death certificate be executed size been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
	tuires that n signed b	þ	Part II. Other significant condition	s contributing to death b	eut not resulting in lhe u	nderlying cause give	en in Part I.		co use contribute to to	
of Vital Records,	e law requir has been si je 2 should b	Completed						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
E H	, , , , , , , , , , , , , , , , , , ,							performe 1 ☐ Yes 2 €		2 No
ΖÏ	Physician: Th rthis certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	26. Place of Death	/	- 5 /2	
	ding Physician: After this certific funeral director,	i. To	27. Manner of Death	28a. Date of Inju		" 3L DOA	4 C Nulsing Hon	8d. Describe how	e 6 Other (Specification)	y)
ion	Manding I death. ctor: After y the funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		y Year) Injury		(? Yes 2 □No			
Division	I or Attanding after death. Director: After I in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, str c. (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	edical C		Physician: To the best xaminer: On the basis of and manner sta	f examination and/or in					
	To the within To the	Me	29b. Signature and title of certifier	1		29c. License	number	29d	Date signed (Month,	Day, Year)
)	مَم		Loveen Pa	thumano	MD	0599	524	No	vember	9,2007
	5		30. Name and address of person w	ho completed cause of d	teath (Item 23a) (Tyne	Print)				
			LOVEEN J. PUTE	IUMANA 31	10 GRACEF	1ELD ROAH	D SILVE	RSPRIN	6, MD 20	904
	Sta Registr		NOV 13	2007 32 Gegistra	ar's Signature	roll				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ii yiaiiu		tificate of	Death	R	eg. No. 2	107	3803
	Physicia	an	1. Decedent's Name (First, Middle, Li						2. Date of Dea Month Novembe		2007	3. Time of Death 8:15 A
	/Medic	al	John Patrick M 4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of Death	NOVEIID		ity of Death	
)	Examin	er	Gilchrist Hospic				Towson			Balt	imore	
	Funeral Director		161-42-3852	Sex 7. Age 1 Mg M 2 □ F	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 15	, ^{Year)} 1951	9. Birth Cou Penns	place (State or Foreig ntry) sylvania
	and w t		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loc	cation					10d. Inside City Limit
	Mary i-f sho fied a	tor	MD Baltimo	re	Halet	horpe						1 □Yes 2.□N
	th the or 28a e noti	Director	10e. Street and Number				10f. Zip Code			0g. Citizen o	of What Cou	intry?
	ath wi	ral	1246 Circle Drive				21227			USA	ace - Ameri	ann Indian
200	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25b or other at unatte event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2□ Married 3 □ Widowed 4 ሺ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:		1	Vas Decedent of H f Yes, specify Cuba I □ Yes 2፟፟፟ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	В	lack, White,	, etc.
ה ה	72 ho natur Jical f	Completed	15. Decedent's E (Specify only highest g.	ducation rade completed)		(Give	lent's Usual Occup kind of work done	durina most of work	ing 1	16b. Kind of	Business/Ir	ndustry
7	vithin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5-	+)	`lif⊕. L alesm	OO NOT use retired	d)		Furnit	ure	
Maryland 21215-0036	filed v Hygie ther t		17. Father's Name (First, Middle, Las	·		aresii	lall	18. Mother's Name				
<u>.</u>	ld be ental ked o	To Be	John Patrick Murt					Margaret	Louise	Hensle	r	
ary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	r, City or Tov	vn, State, Zi	ip Code)
	12 je g		Ann Murtagh McDan	iels/Sister				Rd. Ellic				
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Ches	ce of Dispo netery, cren sapeak	sition (Name of natory or other place ce Cremat	ory 11/0	9/07	20c. Locatio Beltsv		
Dall	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lio	falte	MO125	1 Be	verly L.		e, P.A.	Clark		e, MD 2102
,	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	nplications that caused y one cause on each lin a. Substituting the policy of the pol	05 CU	u car	er the mode of dyin	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Examiner July Landing	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a								
68/60,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	a conseque	nce of):						
. 50X	eath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3]Ectopic pregnanc]Other (specify) _	у			Date of delive	very Day Year
ras, r.	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions	contributing to death bu	ut not resulti	ing in the u	nderlying cause giv	ven in Part I.	23e. Did to			the cause of death?
Vital Records, P.O.		Completed							24a. Was autop perfo 1 Yes			topsy findings availab completion of cause o
/Ita	clan: ertific	Be (25. Was case referred to medical examiner?	l Hannikalı	7. 9.75		Lou	26. Place of Deat				
20	Physi this cral dire	T _o	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien	it 3 DOA Oth	4 Nursing Ho	ome 5 Resid			bity) MOSPICE
0	Attending Physiclan: r death. ector: After this certifics by the funeral director, I	tion	1 Matural 5 Pending 2 Accident investigati	(Month, Day		Injury	Wo	rk? Yes 2∐No	Zod. Describe i	iow injury ou	Janea	
DIVISION OF	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e Place of inju	ury - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Nu vn, State)	mber or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C	29a. Certifier (Check only one) Certifying I	Physician: To the best of amlner: On the basis of and manner sta	f examinatio	ledge, deat on and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	and due to the rred at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	_			29c. Licens			29d. Date sig	ned (Month	n, Day, Year)
	-9		Aum	m				8303		Novem	her &	2007
É	1925		30. Name and address of person wh	completed cause of de	eath (Item 2	23a) (Type,	Print) RLCS ST	Tenson a	no zizi	04		
	Sta Registi		31. Date filed (Month, Day, Year)	2007 32. Régistra	ar's Signatu	3 19	books					

Ronald Gregory N	•	- For State	St	ate of Mary	land / [Departmo Certifica	ent of ate of	Health a Death	and I	Mental H		Reg. N	lo 2	nı	77	380
Physicia		legistrar 1. Decedent's Name	e (First, Midd	e,Last)	-						2. Date of De	eath	y Vear		3. Time o	
Medical Examin	er	Ronald (<u> </u>			Novemb	er 21	, 2007 4c. County of		0833	3 nrs
7 /		4a. Facility Name (i 1248 Pine (n, give street and r	number)		4	b. City, Town Hagersto		cation of Dea	ith		Washing		1	
Funeral	-	5. Social Security N		6. Sex	7. Age (I	n yrs. last birl	thday)	If Under 1	/ear	If Under 24H		Birth (M	(M/DD/YYYY)	9. Bir Foreig	thplace (S	State or
Director	- i	215-13-50		1X M 2 F		21	Yrs.	Months [Days	Hours M	Oct.	L7,1	L986	Co	untry)Ma	ryland
		Usual Residence o			146	c. City, Town	and needing								10d. Ins	ide City Limits
ow any		10a. State Maryland	10b. County	nington	10	-		" rstown								res 2 X No
Syland syland a-f she	황	10e. Street and Nu					nage	10f. Zip Cod				10g.	Citizen of Wh	at Cou	ntry?	
the Marylan a or 28a-f s	Director	11113 I	incol	Avenue				21	740)		US				
death with the Maryland or items 23a or 28a-f show must be notified at once		11. Marital Status		A	ecedent Ev Forces?	er in U.S.	13. Was	Decedent of	f Hispa Jban, N	anic Origin? (Mexican, Pue	Specify Yes or rto Rican, etc.)	No-	14. Race White		rican India	an, Black,
r death or ite	Funeral	1 X Never Marri		Arried 1 Yes	2 X	No		Yes 2 X					Specify:	wh	ite	
us afte		3 Widowed 15. Decedent's E		or Dates:		eted) 16a.	Deceden	's Usual Occ	upatio	n (Give kind	of work done	16	b. Kind of Bu	siness	/Industry	
72 hou nad	Completed by	Elementary/Sec		College	(1-4 or 5+)			st of working	lite. L	OO NOT use i	retired)	İ		- 1- ·		
9036 within iene.	dmo	12	/E: 14:3-3:-	2			cook		1 18	8 Mother's Na	me (First, Midd	le, Maio	pizza den Surname		Jp	
215-0036 be filed within 7 that Hygiene. rked other than ent, the Medica	Be C	17. Father's Name Jeffrey		e, Lasi)						Lisa E	Beckley					
212 ould be ould be s mark	10 1	19a. Informant's N		ship (Type, Print)							or Rural Route					de)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Lisa Sea		mother				Egret ition (Name o			nanicsbu Date		Pa			state
Ore, ges I as of He: I frite		1 X Burial 2	Crematic	n 3 Remova	I from State	crema	atory or otl	ner place) n Ceme			L/26/07		Jagersi	t own	n. Ma	ryland
Itimo it. Pag rtment ortant:		4 Donation 5	Other S	Specify: e Licenses	-	Kest		lame and Add			MINNIC					
Ba perm Depa Impo	9	5/2	XIV	nini	nue		41	5 E. W	ils	on Blv	d., Hag	gers	stown,	Md.	. 217	
Physician		23a. Part I. Enter t failure. List o	he disease, only one caus	or complications that e on each line.	at caused th	ne death. Do r	not enter t	he mode of d	ying, s	such as cardia	ac or respiratory	arrest	, shock, or he	art		oximate Interval reen Onset and Death
'Medical aminer		Immediate Cause or condition result		e a. <u>Methad</u> Due to (or a			on		_						-	
		Sequentially list of	_	b	as a conseq	derice or).										
	iner	if any, leading to i	mmediate	Due to (or a	as a consec	uence of):										_
- W =	Examine	(Disease or injury events resulting in		Due to (or a	as a consec	juence of):										
0, E be executed sician and burial - transit	dicalE	Tpeupe		d											+-	
50, te be ex ysiciar burial	a a	X UNPENDE	J	#23a	.27,28	a-f. per e of pregnanc	ME.g8	75, 1/17	7/08	S TT			23d. Date of	of delive	ery	
68760, certificate be nding physici	an/N	23b. Was deceder past 12 month	nt pregnant in ns?	the 1 Li	ve birth	ime of death	2 F	etal death	3	Ectopic pre	egnancy		Month		Day	Year
Box (e death or the attenued for us	Physician/M	1 Yes 2	No 9 🔲 U	nlenoum	nknown	ille or death	5 O	ther (Specify) _			-				
		Part II. Other sig	nificant cond	litions contribution	ng to death	but not result	ting in the	underlying ca	use g	iven in Part I.			acco use con			
S, P.	ed by										- /	Yes Was an				4 Unknown
ords Iw requas beer	plet										8	autopsy	/	prior to death	o complet	ion of cause of
Rec The la Tre la ricate h	Completed							- 00	Disease	of Dooth (Ch		res 2	No	1 🗸	Yes	2 No
Division of Vital Records, P.O. the Hospital or Attending Physician: The law requires that the hin 24 hours after death. The Funeral Director: After this certificate has been signed by repletely filled in by the funeral director, page 2 should be detact	Be	25. Was case ref examiner?		Hospital:	Inpatier	nt 2 ER	/Outpatier			0	eck only one) ursing Home	5 R	tesidence 6	✓ Ot	her: Scen	е
of V g Phys g er thi neral di	<u>۔۔</u>	1 Yes 27. Manner of De	2 No	28a. [Date of Injur		b. Time of		c. Injur	ry at Work?	28d. Desc	ribe ho	ow injury occu	rred		
On tendin eath.	ation	1 Natural 2 Accident		ending Fno	1 11/21	/2007 Fi		/ am		res 2 X No						
Division tall or Attendii rs after death.	Certification:	3 Suicide	6 X C	ould not be 28e.		ury - At home	e, farm, str	eet, factory, o	ffice b	uilding, etc.	28f. Locat or To	tion (Sta wn, Sta	reet and Numate) Crest,	ber or	Rural Rol	ute Number, Cit
Division 1. Hospital or Attend 2. 4 hours after death Funeral Director:		4 Homicide	•	Physician: To the		use	death occi	urred at the ti	me da	ate and place	70.00			-		wii, ib
To the Hos within 24 h To the Fun completely	Medical	(Check only 1 one) 2		xaminer: On the ba	asis of exan	nination and/o	or investig	ation, in my o	pinion	, death occur	red at the time,	date a	nd place, and	I due to	the caus	e(s)
To To cor	Me	29b. Signature a	nd title of cert		l stateu.					e number			29d. Date sig			ay, Year)
		Mo	youte	The	Shull				0.C.I	M.E.			Novembe	er 22,	2007	
		30. Name and ad	_	on who completed . Assistant			a) 111 l	Penn Stre	et, B	altimore, I	MD 21201					
9	tate	51 5 1 61 1 11				r's Signature	-									
Regis				e 2007	Es .	2 20	A. Carlotte	S. D. B.								
DHMH 17 Rev 1/3	2001			- CARLES			RIGIN	AL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		Cer	tificate of	Death	F	Reg. No. 2 (107	38035
	Physici	an	Decedent's Name (First, Middle,					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Oliver 4a. Facility Name (If not institution,		ladeau	4b. City. Town, o	r Location of Death	NOVEMBE	4c. County		2:15 P. M
	Examin	ier	11610 Zennia A			Cumbe			Alleg		
	Funeral Director		212-40-6598	. Sex 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 10	, 1925	9. Birthplac Count	ce (State or Foreign Canada
17.7°	land ow it		Usual Residence of Decedent 10a. State 10b. County		, Town or Loc					10d	d. Inside City Limits
	a-f sh ified a	ctor	MD Alleg	any	Cum	berland					Y⊒Yes 2□No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 11610 Zennia A	venue		10f. Zip Code	21502		10g. Citizen of	What Country ISA	1?
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Vas Decedent of F f Yes, specify Cub I □ Yes 2 □ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	Bla	ce - American ck, White, etc	c.
5-0036	2 hour		15. Decedent's	Education	16a. Deced	lent's Usual Occup	oation	king	16b. Kind of B		
2	ithin 7 ne. nan "n e Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worl d)	king	OB/GY	'NI	
2	filed within 7 I Hygiene. other than "r ent, the Med	Cor	17. Father's Name (First, Middle, La	ast)	Docto	1	18. Mother's Nam	ne (First, Middle,			
land		To Be	Henry Nadea					reapeau			
Mary	alth and N alth and N 27 is man		19a. Informant's Name/Relationship Patricia Nadeau	(Type. Print) wife	19b. Mailin 116	g Addr <u>es</u> s <i>(Street</i> 10 Zennia	and Number or Ru a Avenue	ral Route Numbe Cum	pr, City or Town berland	, State Zin C	^{oda} 21502
saltimore,	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 is marke Injury or other traumatic e.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	B⊟Removal from State Sca	Place of Disponentery, cremetery, cremeter, cremetery, cremeter,	sition <i>(Name of</i> natory or other pla neral Home		Date 11/19/2007	20c. Location Cresa	- City or Towi Iptown	n, State MD
Ball	permit. Pag Department Important: It any Injury o		21. Signatur of Funeral Service Li	FIM.	1	108 Virg	ระคบ ์ก็ย่∜ ăi Ho ginia Avenue:	: Cumberlar		502	
ı			23a. Bart 1. Enter the disease, or c shock, or heart failure. List o	omplications that caused the death	n. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	A Ju	Approximate nterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a LUNC	1 0	ANCE					MON THS
	/Medical Examiner		1	Due to (or as a conseq	uence of):						
		ner	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conseq	uence of):						
r	ecutec and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	unnes of):						
68/6 0,	be ex	al E		Due to (or as a conseq	uerice or).		,^				
28	rtificate be executed ng physician and as the burial-transit	Medical		d			/				
O. BOX	The law requires that the death cer te has been signed by the attendin tage 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	l death 3□	Ectopic pregnanc Other (specify)	у			ate of delivery onth D	y Day Year
7.	s that t ned by e detac		Part II. Other significant condition	s contributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to the	cause of death?
Spa	equires en sig ould be	ed by	AIRIM FI	BRILATION	1, 0	ORON	AR	1 🗆 \	res 2 □ No	3 ☐ Probat	bly 4 Unknown
Hecords,	40 5	Completed	ARTERY.	DISEASE					an 24b. osy rmed? 2 → No	death?	sy findings available pletion of cause of
N [[a]	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		l Ott	201	th (Check only o			
ō	Phys	1. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time of	IL OLI DON	4 Li Nursing n	ome 5 Resid			
VISION		atior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury		rk?]Yes 2⊟No				
DIVIS	al or Atte s after de: al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rural I	Route Number,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (Physician: To the best of my kno xaminer: On the basis of examina and manner stated.							
	To t To tl	Ž	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month, D	ay, Year)
			Sm	Hluss		D540	04		/	10//	
- 0	20		30. Name and address of person w	ho completed cause of death (Iten	127	DIFIN	MONA	LHny	LAVAL	E, MI	091202
	Sta Registi		NOV 2		15 1	foods					

DHMH 17 Rev 1/2001

	te qistrar		of Marylan		rtificate of				No.	U /	3803
1. Deced	dent's Name (First, Midd	die, Last)					2. Date Mor	of Death	Day	Year	3. Time of Death
n <u>ALAN</u>	JULIAN NE	WMAN							10, 2		11:15a
	lity Name (If not institution	on, give street and	i number)		4b. City, Town, o	r Location of	Death		4c. County	of Death	
	RIAGE HILL (BETHESDA If Under 1 Year		4 Hrs. a B.	- (Di-th	MONTG		
578-	-52-7653	6. Sex 12€ M 2□	F 7. Age (In yrs.		Months Days	Hours	Min. 05/	of Birth oth, Day, Yo 28/19:	39	WASH	place (State or Forentry) INGTON, I
10a. Sta	esidenca of Decedent ite 10b. Count	ly	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Lim
MARY	LAND MONTG	OMERY	BETH	ESDA							1 ∑ Yes 2 □
MARY 10e. Stre	eet and Number				10f. Zip Code			10g	. Citizen of V	What Cour	ntry?
	HIDDEN CR	EEK ROAD			20817			U.	S.A.		
11. Mari	tal Status	12. Was I	Decedent Ever in U. d Forces?	.S. 13.	Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Yes Puerto Rican, e	or No-		e - Americ	ean Indian, etc.
3 □	Never Married 2☐ Ma Widowed 4 ☐ Divorce	arried 1 ☐ Y	es 21 No Give or Dates:	1	1 ☐ Yes 2 ☐ No				Specify	T 777	ITE
Eleme		ent's Education lest grade complet	ted)	16a. Dece	dent's Usual Occup	ation during most of	of working	16	b. Kind of Bu	usiness/In	dustry
Eleme	entary/Secondary (0-12)		ge (1-4or 5+)	lite.	DO NOT use retire	d)					
	4-81		5+	PEDIA	TRIC DEN		'a Nama /First		ENTAL	20)	-
17. Fath	ier's Name <i>(First, Middle</i> JEL BERNARD	,					's Name <i>(First,)</i> NE MILL		uen suman	13)	
_	ormant's Name/Relation				ng Address (Street						
JAY	FREEDMAN,	BROTHER	IN LAW	7221	HIDDEN C	REEK R	OAD, BE	THESD	A, MAF	RYLAN	D 20817
1	thod of Disposition	0. 🗆 🗆		comotony cro	sition (Name of matory or other pla	ce)	Date		c. Location -	-	
	XBurial 2 ☐ Cremation]Donation 5 ☐ Other (GAR	DEN 8	IREMENER.	ANCE 1	1/13/20	07 CL	ARKSBU	JRG,	MARYLAND
21. Sigr	nature of Funeral Service	e Licensee		2: E	2. Name and Addre DWARD SA U91 ROCK	ess of Facility	NERAL D	IRECT	ION, 1	INC.	
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Immedi	nock, or heart failure. Lis iate Cause (Final										Onset and Death
resultin	or condition g in death)	a. SEP	o L o e to (or as a conseq	mence of):						-	
		b DYS	PHAGIA	,001100 01).							
Sequen	itially list conditions,		PHAGIA e to (or as a cons								
Sequent cause. Cause (that initial	ntially list conditions, eaching to him edials Enter Underlying (Disease or injury lated events	c. PAR	e to lor as a conse. KINSONIAN	uence of):	NEUROMUS	CULAR	DEGENER	ATIVE	DISE	ASE	
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resulting	ated events g in death) Last ALE:	c. PARi Due d	e to for as a consequence of or as a consequence of pregnation, outcome of pregnation	uence of: I-LIKE uence of): ancy al death 3[DEGENER	ATIVE	23d. Da	te of delive	-
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		-	For State Registrar	State of Ma	aryland		artment of He tificate of D		l Mental Hyg	iene 007	38037
			Decedent's Name (First, Middle, Las.	t)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		Ruth R. Nush	oaum					Novembe	r 3, 2007	2232 M
	Examin		4a. Facility Name (If not institution, give Carroll Hospital				4b. City, Town, or Westm	Location of De inster	ath	4c. County of Dea	
	Funeral Director		Social Security Number 6. Security Number		e (In yrs. Ia 86	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year) 9. Bir Co , 1921 Ma	thplace (State or Foreign buntry) ryland
	D		Usual Residence of Decedent		100 City	Tour or Lo	ection				10d. Inside City Limits
	arylar show	5	10a. State 10b. County Marvland Carr	-011	TUG. City,	Town or Lo		estmins	ter		1 ☐ Yes 2 No
	the M	ecto	Maryland Carr	OTT			10f, Zip Code			0g. Citizen of What Co	ountry?
	with 3a or		1837 Clearview Ro	ad				2115	8	US.	•
	death ms 2; rmm	nera	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S	S. 13.	Was Decedent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whi	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 M Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	40		1 ☐ Yes 2, MINo	Specify:	one mean, etc.,	0	hite
9	2 hou	ted t	15. Decedent's Ed	ucation		16a. Dece	dent's Usual Occupa	ition	dein m	16b. Kind of Business	/Industry
215	hin 73	ple	(Specify only highest grades) Elementary/Secondary (0-12)	de completed) College (1-4or 5	i+)	life.	kind of work done d DO NOT use retired;		vorking	0 - 11	_
2	ed wit	Completed	11				Homemake			Own Hom	e
Baltimore, Maryland 21215-0036	d be fill ental Hy ced oth	Be	17. Father's Name (First, Middle, Last) William George	e Rumbold					Name (First, Middle, I Duise Clar		
ZZ.	shout nd Me mark	2	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address (Street a	nd Number or	Rural Route Number	, City or Town, State,	Zip Code)
Ž,	s 1 and 2. of Health ar item 27 Is other trau		Karl W. Nusbaum,	son		1166	Hester A	ve, Sar	n Jose, CA		
ore	of He of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other place	e)	100	20c. Location - City or	
Ē	Pag tment tant:		'4 □Donation 5 □ Other (Specify	<i>(</i>)		arroll	Cremator	V	11/09/2007		
Ba	Depar Impor any in		21. Signature of Funeral Service Licen	Sentron) 1	36 E. Bal	timore	Myers-Durb St, Taney	oraw Funer town, MD 2	1787
			23a. Part 1 Enter the disease, or comp	olications that caused	the death.	. Do not ent	er the mode of dying	g, such as card	diac or respiratory arr	est,	Approximate Interval Between
Ł	Pnysician		Immediate Cause (Final disease or condition	a Veni	ina	lar	timile	etion			Onset and Death 8 Hours 10 yearn
	/Medical Examiner		resulting in death)	Mue to (or as	a consequ	ence of):	Dond	1-5/60	eculas.	likeon	10 yeary
		-e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ		Care	1000	2 /	70175	. 0
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):					
8760,	cate be executed physician and the burial-transit	dical	(. d							
9	entific ding p		IF FEMALE:	23c. If yes, outcome	of pregnar	nev				23d. Date of de	divor
Вох	that the death certif ed by the attending detached for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[Ectopic pregnancy Other (specify)			Month	Day Year
0	the d by the ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown							
S, P	es gu	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	lting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ord	w requir been si should	eted							-		
Rec	has b	Completed							24a. Was a autop: perfor	sy prior to med? death?	utopsy findings available completion of cause of
a		e Co	25. Was case referred to medical					OC Blanc of I	1 ☐ Yes Death (Check only or		s 2 No
₹	/sicie s cert	To Be	examiner?	Hospital:	ent 2 🗆 E	ER/Outpatier	nt 3 DOA Othe	ar		ence 6 Other (Sp	ecify)
n of	Attending Physicien: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	iry	28b. Time o	The state of the s	at		ow injury occurred	
Sio	eath. or: Af	catlo	2 Accident investigation	1			M 10'	Yes 2 □ No	- 1		
Division of Vital Records,	after d Direct Jin by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et			reet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	lural Houte Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best niner: On the basis o and manner st	f examinati	wledge, deat ion and/or in	h occurred at the time vestigation, in my op	ne, date and ploinion, death o	ace, and due to the c ccurred at the time, c	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the within To the Complete	Me	29b. Signature and title of certifier	1.1.0.0.		Δ.	29c. License			29d. Date signed (Mor	
}	MJL		Mobiled	in vage		7	DOG	N(27C	80	11-5-0	/
	Ma		30. Name and address of person who CHITRACHED U	completed cause of a	death (Item	23а) (Туре, Р D	Print) PA. 70	0-A P	rosle Nd	WESTM	INSTER
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 9	32. Registr	rar's Signat	ture	South?				
			TO VON	LUUI JUGA		N	CHICAGO.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 **Physician** 2007 6:50 P M George Neustadt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4 Holly Court Ocean Pines Worcester 8. Date of Birth (Month, Day, Yea 5/1/1920 If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □X M 2 □ F 87 Director 154-01-2191 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 ☐ Yes 2X No Funeral Director MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 4 Holly Court USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Carrier Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hyman Neustadt Minnie Levitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Holly Court, Ocean Pines, MD 21811 Judith E. Neustadt / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 11/12/2007 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 Part1. Enter the disease, or complic shock, or heart failure. List only one Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) For home Physician Renal /Medical Due to (or as a consequence of) Examiner CVA Sequentially list conditions, if any, leading to immediate cause. Enter Uncountry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed hysician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐ Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 s autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident Injury 5 Pending s after death.

al Director: A 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Type, Print) 5. DIV- 5 New SACISBURY BA15+1 NATESAN 1415 32 Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 3 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 38039 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 450 MM MARIAN OLIVER 0 07 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner WICOMICO AKE SALISBURY OASTAL HOSPICE AT THE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TX F 4/12/1924 83 Pennsylvania Director 186-16-2806 Usuat Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is merked other then "natural", or Itema 23s or 28a-f ahow ury or other traumatic event, the Madrial Examiner must be notified at 1 X Yes 2 □ No Delaware Media Pennsylvania Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 501 N. Providence Rd., Apt. 319 19063 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decadent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No white Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) District Attorney Office manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J. Warren parker Sr. Lillian Massey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27103 Patriot Dr., Salisbury, MD 21801 Suzanne O. Grudis/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or otl 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Salisbury Crematory 11/8/07 Salisbury, MD

22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ral Service Licensee A3a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat BRRAST ARCI NOMA Physician resutting in death) /Medical Due to (or as a consequence of): Examiner BND STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐ Unknown 9 Unknown as been signed by 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 2 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy page performed' this certificate 1 Yes or Attending Physicien: ector, 26. Place of Death (Check only one 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No Hospital: Impatient 2 ☐ ER/Outpatient 3 DOA Certification: To funeral dir 28a. Dite of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1_ Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00058410 Ugu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Bo 4 1713 SHIS MU & up 21801 COASTAL ITOSPICA WAR 9 ETHENTSH 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State NOV 09 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 9, 2007 **Physician** Wilson Jerome Purdy, Jr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Lanham Doctor's Community Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☑ M 2 □ F Yrs. February 05,1938 Washington, D.C. 69 Director 577-52-1467 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ginee. 1 ☐ Yes 2 ☑ No Directo Lanham Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20706 U.S.A. 6510 Westview Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ould be filed within 72 hours after Mental Hygiene. arked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify: Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Giant Food, Inc. Director of Produce Merchandising 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Theresa Magill 2 Wilson Jerome Purdy, Sr. Pages 1 and 2 should nent of Health and Mer Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6510 Westview Lane, Lanham, Maryland 20706 Barbara A. Purdy - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 11/13/2007 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) ARRHYTHMIA UNKNOWN Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner death certificate be executed burial-trar Due to (or as a consequence of) physician the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION ATRIAL 24a. Was an has le 2 page STENOSIS 1 ☐ Yes 2 ☐ No certificate CAROTIO or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after con-1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MDD 61637 MO NOVEMBER 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Parago Prizart 575 Main St., Suite 351, haurel, Mb. 20107 32 egistrar's Signature 31. Date filed (Month, Day, Year) State 1 3 2007 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** 12:03 P M November Joyce E Perez /Medical 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick Examiner If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F Director 64 9/26/1943 Ohio 296-38-5372 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show r 28a-f show notified at Y☐Yes 2☐No Maryland | Frederick Walkersville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code nd Mental Hygiene. marked other than "natural", or Items 23a or imatic event, <u>the Medical Exa</u>miner must be r 8371 Discovery Boulevard 21793 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify White Specify: 2 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Administrative Assistant Hospital permit. Pages 1 and 2 should be file. Department of Health and Mental Hygi Important: If item 27 Is marked any Injury or other to once. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Henry Alvin Weaver Emma Louise Weaver Stinnette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laura S. Filler - Daughter P.O. Box 586 New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/10/2007 Baltimore, Maryland Holy Cross Catholic 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home, 934 South Mo1490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OFO Ca /Medical Due to (or as a consequence of): Huperters Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a own equence of) Examiner Due to (or as a consequence of) physician Physician/Medical as the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1 Yes 2 € Mo 1 ☐ Yes

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate To the Hospital or Attending Physician: after death.

Director: After this certification by the funeral director, within 24 hours aft

To the Funeral Di

completely filled in

filed within 72 hours after

Saltimore, Maryland 21215-0036

Be မှ Certification:

MJI 3

Medical

State Registrar 25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manner of Death

1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

29a, Certifier

6 ☐ Could not be determined

(Month, Day Year) 5 Pending investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury

1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work?

to critifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 □ Yes 2 □ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

MDH 40539

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

Molesworth 400 W.

31. Date filed (Month, Day, Year) NOV 09 W. 7th St., Frederick, MD 21071
32 Regionar's Signature

Physician /Medica Examine For

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

•	1 - State Registrar		Cert	ificate of L	Death		Reg. N	-200	7	38	142
	1. Decedent's Name (First, Middle, Last)					2. Date of Di Month	D.	ay Ye		3. Time of	Death
	Susan	Pilaitis				Novemb	er 1	L3 200		241	РМ
	4a. Facility Name (If not institution, give street an	nd number)		4b. City, Town, or	Location of De	eath	4	c. County of D	eath		
	Union Hospital			E1kton				Ceçi1			
	5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, D	rth <i>ay</i> , Yea		Birthplac Country	e (State o	or Foreign
	1/9-34-15/3	63	Yrs.			OCT 23	, 19	944 Pe	ennsy	1van	ia
	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loca	ation					10d	. Inside Ci	ty Limits
5	,									1 🗌 Yes	2 X No
מבי	Maryland Cecil 10e. Street and Number	· Li	arlevil	10f. Zip Code			10a. C	itizen of What	Country	?	
5									_		
0	645 Knights Island R	Oad Decedent Ever in U.S	S 13 W	21919	enanic Origin?	(Specify Yes or N		Jnited 14. Race - A			
5	Arm	ed Forces? Yes 2 X No	IS. If	Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)			Vhite, etc		
2	If Ye	es, Give Ar r or Dates:	1	∐Yes 2∭X No	Specify:			Specify:	White	e	
2	15. Decedent's Education		16a. Decede	ent's Usual Occup	ation		16b.	Kind of Busine	ess/Indus	stry	
Inplet	(Specify only highest grade compl	eted) ege (1-4or 5+)	(Give k life. D	ind of work done o O NOT use retired	furing most of ()	working					
5	Elementary/Secondary (0-12) Coll 12	ege (1-401 5+)	C1e	rical				Law Fi	rm		
ט ע	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middl	e, Maide	en Surname)			
0	Fenton L. Carr				Gerti	rude L. E	lowe	rsox			
	19a. Informant's Name/Relationship (Type. Prin	t)	19b. Mailing	Address (Street	and Number of	r Rural Route Num	ber, City	or Town, Sta	te, Zip C	ode)	
	Michael Pilaitis/Son	1	187 W:	ickershar	n Road,	Oxford,	Pen	nsylva	nia_	19363	3
	20a. Method of Disposition	20b. P	lace of Dispos emetery, crem	ition (Name of atory or other place	e) Nov	_{Date} vember		Location - City Philade			
	1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)		ıladel; emator	atory or other plac phia ies	17	2007	1	Pennsy1	vani	ia _	
	21. Signature of Funeral Service Licensee)	22.	Name and Addres	ss of Facility	nerals,_	D A				
19	Busten High	uman	10	3 W. Sto	ckton S	treet, E	1ktc	n. Mar	ylan	d 210	921
	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death e on each line.	n. Do not ente	r the mode of dyin	g, such as car	diac or respiratory	arrest,		l Ir	pproxima nterval Be	tween
ı	Immediate Cause (Final disease or condition	Premie							7	nset and	Death
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ealcai	d	COPD									
Mec	IF FEMALE:							Ī			
au/	23b. Was decedent pregnant	es, outcome pf pregna Live birth 2 ☐ Feta	I death 3□	Ectopic pregnancy	,			23d. Date o Month	,		Year
Pnysicia	1 T Voc 2 12 No 4 4]Pregnant at time of d]Unknown	eatn 5⊔	Other (specify)							
	Part II. Other significant conditions contributing	a to death but not res	ulting in the un	derlying cause giv	en in Part I.	23e. Did	l tobacc	o use contribu	ite to the	cause of	death?
completed by	Couredie Hea		200			1 []Yes	2[XNo 3[] Probal	bly 4 □	Unknown
erec	Coupertoc (re	, , , , , , ,				-		0.45 144-			
T D							is an lopsy rformed	? Z4b. we prio	r to comp th?	pletion of	available cause of
_						1□ Yes	2		Yes 2	□ No	
ğ	25. Was case referred to medical examiner?	- X		Oth	er.	Death (Check onl)					
0	I Tes ZETAO	1 ☑ Impatient 2 ☐ . Date of Injury	ER/Outpatient 28b. Time of	3 DOY	4 LI Nursir	ng Home 5 ☐ Re		6 ∐Other of the figure occurred	(Specify)		
0	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injui Wor M 1 □	k?ື Yes 2∐No	200. 2000113		,,,			
Cat	3 Suicide 6 Could not be	Place of injury - At ho	ome, farm, stre			28f. Location	(Street	and Number	or Rural I	Route Nu	mber,
ELL	4 Homicide determined	building, etc. (Specif	y)			City or 7	own, St	ate)			
ت ص	29a. Certifier 1 Certifying Physician:	To the best of my kno	wledge, death	occurred at the ti	me, date and p	place, and due to the	ne cause	e(s) and mann	er as sta	ted.	
Medical Certification:	(Check only 2 Medical Examiner: Or one)	n the basis of examina d manner stated.	tion and/or inv	estigation, in my	ppinion, death	occurred at the tim	e, date	and place, and	due to t	the cause	(S)
Me	29b. Signature and title of certifier			29c. Licens			29d.	Date signed (/	Month, D	ay, Year)	
	I for coo IVA	- MD		DO	482	3		11/14/	07	•	
	30. Name and address of person who complete	d cause of death (Item				, ,		- (2	~ ^ 1
	JUL CHIH HS	in, MD	22	FROW E	mai	ict.	FK	toe.	Ma	21	92/

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 5 2007

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** CHARLES PENNEWELL, JR. GRANVILLE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomies Keninswa Kegiina Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/25/1940 9. Birthplace (State or Foreign Social Security Number 6 Sex 7 Age (In vrs. last birthday) **Funeral** Hours Months Days Mary land 1**∑** M 2□ F 67 Director 219-36-7167 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Tyes 2 No Director Pocomoke MD Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21851 33032 Peach Orchard Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: white Completed by 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Hurley Granville Charles Pennewell, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 33032 Peach Orchard RD., Pocomoke, MD 21851 Gloria Pennewell (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 11/13/2007 | Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home, Professional Association 21. Signature of Funeral Service Licenses 103 Linden Ave., Pocomoke City, MD 21851 Dean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Meta Stabie adeNO Carcinoma disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Kepatic Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 1□ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ **K**o 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

Physician /Medical Examiner

permit. Pages Department of H Important: If ite any injury or ot

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Maryland 21215-0036

Baltimore, I

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

sician and burial-tran physician the as for page 2 s

certificate be executed

Box 68760.

P.O.

Records,

Division or Vital or Attending Physician:

certificate funeral After t hours after death. Director: d in by the in 24 hours the Funeral Directory the Funeral Directory

5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rernando ACLE 31. Date filed (Month, Day, Year)

NOV 1 3 2007

100 & CANOIL 32. Registrar's Signature

State Registrar

within 24

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Medical

one)

			1 - For State Registrar	State of Maryla	nd / Depa	artme		lealth and	•	lygien	9007	38044
	Physic		1. Decedent's Name (First, Middle, Last)). Parrott		runca	110 01 1	Jean	2. Date of Month	Reg. No Death Da	y Year	3. Time of Death
	/Medic Examir		40. Fecility Name (If not institution, give s Coastal Hispia at H	treet and number)		4b. Cit	40	Location of Dea	ıth		County of Dee	th
	Funeral Director		5. Social Security Number 6. Sex 216-01-5348 Usual Residence of Decedent	7. Age (In yrs. 87	last birthday) Yrs.	If Und Month	der 1 Year s Days	If Under 24 Hr Hours Mir	. (Month,	Birth Day, Year,		thplace (State or Foreign buntry) ryland
	Maryland -f show	tor	10a. State 10b. County Maryland Wicomic		ty, Town or Lo							10d. Inside City Limits
	h with the	Funeral Director	10e. Street and Number 28573 Ocean Gatewa	ay		10f. 2	Zip Code	1			tizen of What Co	Duntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "netural", or items 23e or 28e-f show any highly or other traumatic event, the Modical Exercities I said by hullified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:			cedent of Hi becify Cuba 2 12 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or rto Rican, etc.)		14. Race - Ame Black, Whit	
21215-0036	within 72 ho ane. than "nature he Medicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)		dent's Us kind of v DO NOT SEW1	vork doné d use retired	ation furing most of we)	orking		ind of Business	Industry
Maryland 2	should be filed ind Mental Hygi in marked other umatic event, II	To Be Co	12 17. Father's Name (First, Middle, Last) William Donaway		HOU	SEWI	re	18. Mother's Na	ame (First, Midde e Maybe.	de, Maider	•	
	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type Karen H. Potter/da	•		-		and Number or F Gateway				
Baltimore,	Pages 1 ment of H ant: If Ital ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cren rsons (natory or Ceme	other place terv	11,	Date /15/07	Sa	ocation - City or	, MT)
Balt	permit. Departr Imports any inju	4	21 Signature of Funeral Service License	DON CESP	22	Ho1 501	Ioway Snow	Funera Hill Ro	l Home I	Profe	ssional y, MD 2	Association 1804
17	Physician		23a. Part1. Enter the disease, or comblic shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.	th. Do not ent	er the mo	ode of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
Ì	/Medical Examiner		resulting in death) Sequentially list conditions, b.	CITRONIC Due to (or as a consec RRCTA	juence of):	AR	c/1	omA				
,097	ate be executed nysician and he burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	uence or):							
9	ing physic as the c	Medicai	d.									
O. Box	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	ic. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of constant in the constant in	Ideath 3	Ectopic Other (s	pregnancy specify)			-	23d. Date of del Month	ivery Day Year
rds, P	w requires that been signed E should be deta	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	nderlying	cause give	n in Part I.		d tobacco t	_	the cause of death?
Vital Records,		Completed							24a. Wt au pe 1 □ Yes	topsy rformed?	prior to death?	topsy findings available completion of cause of
T VII	dis X	To Be	25. Was case referred to medical examiner? 1 Yes No Ho	espital:	ER/Outpatient	t 3 🗆 D	Othe	26. Place of De			6 □Other (Spec	cify)
	ding After fune		27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	М	28c. Injury Work 1 🗆 Y		28d. Describ			
ž N	To the Hospitel or Attant within 24 hours after deat To the Funaral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or T	own, State)	ral Route Number,
	a Hosp Lot hound to Funa bletely fil	edicai	29a. Certifier Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurre estigatio	d at the timen, in my op	e, date and place inion, death occ	e, and due to th urred at the time	e, date and	and manner as place, and due	stated. to the cause(s)
	To the comp	Ž	29b. Signature and title of certifier				c. License				te signed (Month	
	584		30. Name and address of person who com	apleted cause of death (Item	1 23a) (Type, f	Print)		3410			-12-0	,
			CHUIAM WARIS	32. Registrar's Signa	HUSPI	ICR	Ro	BOXIT	137,5	ALis	sury	mb 51805
E	Stat Registra	_	31. Date filed (Month, Day, Year) NOV 1 3 200	32. Hogistrar's Signa	Jr A	perto					,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Virginia M. Pruett 2007 4:54 Рм Nov. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min. 220-40-8966 83 March 4, 1924 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Baltimore MD White Hall 1 ☐ Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21161 1029 Wiseburg Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William W. Wolfe Lillian R. Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1397 W. Jarrettsville Rd., Forest Hill, MD 21050 Ginni Zachmeier, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 15, Nov. 3 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wiseburg Cemetery White Hall, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final weeks disease or condition resulting in death) Due to (or as a consequence of): osteo porosis Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events PROVED BY MEDICAL EXAMINER sle resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease COYONAM 1 Yes 2 No 3 Probably 4 Unknown SCAJE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1
Natural 5 Pending Injury Fell while getting ready To go To October 15,2007 11:00 AM 1 ☐ Yes 2 🗷 No 2 Accident Hemodia Cysis 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide MANORCARE-ROSSVILLE BALtimore, md rehab Norsing Facility

The law requires that the death certificate be executed attending physician and P.O. Box 68760. Division or Vital Records, certificate or Attending Physician: After this Director

Hospital

Examiner within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

ud 2 should be filed within 72 hours after death with the Maryland thit and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 s ment of Health an Health tem 27 i

permit. Pages
Department of
Important: If It
any injury or o

Physician

/Medical

Examiner

Physician/Medical þ Completed Be P Certification: Medical

29a. Certifier

(Check only one)

State Registrar 29b. Signature and title of

Year)

(Month, Day,

29c. License number

1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) November 12, 2007

address of person who ampleted cause of death (Item 23a) (Type, Print) N. Charles St. Balto Md 2120x 6701

32. Registrar's Signature MONEY.

and manner stated.

			For State Registrar	tate of Mary		partme <i>ertifica</i>			•	giene Reg. No.		
	Physici		1. Decedent's Name (First, Middle, Last) Richard Alton Ro	SS					2. Date of De Month NOVEMB	ath Day 2	Q _{ea} /	378046 8:00A.M
0	/Medi Examir		4a. Facility Name (If not institution, give stree Reeders Memorial Ho	et and number)		4b. City		Location of Death	THOVEND		ty of Death Washi	
- 1	Funeral Director		5. Social Security Number 6. Sex 1212-24-5228	7. Age (In	yrs. last birthd	Months	er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov.14	th ly, Year) ,1926	9. Birthp Coun	lace (State or Foreign
	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County		c. City, Town o						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ 🛣 0
4	with the Marylan a or 28a-f show be notified at	Directo	Md. Washingto		Smi	thsbu 10f. Z	ip Code	21702		10g. Citizen o		
GZ 9	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	/ Funeral Director	1 Never Married 2 Married	Was Decedent Ever Armed Forces? 1 □ Yes 2 □ No	in U.S. 1	I3. Was Dec If Yes, sp 1 ☐ Yes	edent of Hi ecify Cuba	21783 spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ace - Americ ack, White,	
1244K	c _ 0	Completed by	15. Decedent's Education (Specify only highest grade co	year or Dates: on mpleted)	16a. De	ecedent's Us	ual Occupa		ing	16b. Kind of	Business/Ind	dustry
(7/2	be filed within tal Hygiene. d other than "eevent, the Mec	Be Com	12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		T	echni	cian 18. Mother's Name	e (First, Middle			lectric
USS Maryland	should and Men marke	ToB	Charles Ross 19a. Informant's Name/Relationship (Type.	Print)	19b. M	ailing Addre	ss (Street a	Alice I	L. Slea:		n, State, Zip	Code)
G, K	es 1 and 2 of Health a f item 27 Is r other tra		Elizabeth L. Martin	2	Oh. Place of Di		ame of		burg, Me	20c. Location		own, State
NAME: £	permit. Pages Department of Important: If ii any Injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emperal Service Licensee	oval from State	Smithsh	ourg C	remat		07	Smith 2525 Br	sburg adburi	
NAN	Per De la la la la la la la la la la la la la		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated by the complex of the com					Funeral g, such as cardiac	Home Si	mithsbu		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	rtatie			ane d				Onset and Death
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68760,	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last c	Due to (or as a co	nsequence of):				40-9 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			
Вох	Physician: The law requires that the death certifica r this certificate has been signed by the attending ph ral director, page 2 should be detached for use as the	by Physician/Med	in the past 12 months?	If yes, outcome pf pi 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death	3 □Ectopic 5 □ Other (Date of delive	ery Day Year
'ds, P.O.	juires that the signed by the detaction	d by Ph	Part II. Other significant conditions contrib	-	-		_	en in Part I.				ne cause of death?
l Recol	The law requirate has been sippage 2 should t	Completed	Arteris Schoolie	Cendis V	anal	· Du	منع	-	24a. Was auto perfo	psy ormed?	o. Were auto prior to condeath?	psy findings available mpletion of cause of 2 No
or Vita	Physician: The la this certificate ha ral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hosp 27. Manner of Death	ital: 1 ☐ Inpatient	2 ER/Outpa			4 Hoursing Ho	ome 5□Resi	dence 6 □C		iy)
Division or Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 ☐ Matural 5 ☐ Pending investigation	(Month, Day Ye.	<i>ar)</i> Inju	ry M		Yes 2 □ No	28f. Location (City or To	Street and Num		al Route Number,
	e Hospita 124 hours e Funeral	Medical C	29a. Certifier 1 Certifying Physicia (Check only one)									
	To th withir To th	Me	29b. Signature and title of certifier	P		2	9c, License	e number		29d. Date sign		
	10		30. Name and address of person who compl	O MILL ST	REET,	HAGERS	TOWN,	, MARYLAN	D 21740	301-	-739-7	100
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 8 2007	32 Registrar's	Signature	best	,					

DHMH 17 Rev 1/2001

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Hospital or Attending within 24 hours at To the Funeral D

Maryland 21215-0036

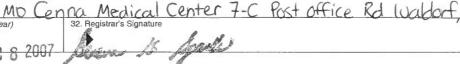
Baltimore,

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

mais 31. Date filed (Month, Day, Year)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

29d. Date signed (Month, Day, Year)

			1 - For Stata Registrar	State of N	/larylan d		artment rtificate			nd Mental F	lygier	2111	7	380) 48
ı	Physic	ian	Decedent's Name (First, Middle,	,						2. Date of Month		ay_	Year		of Death
	/Medi		Daisy 4a. Facility Name (If not institution,	R.		xrode	4h Cib. T			Nov		007		9:45ar	n M
	Exami	ner	Frostburg Village	-	•		Frost		Location of [Jeath		k. County Allega			
	Funeral Director				Age (In yrs. las	st birthday) Yrs.	If Under 1		If Under 24	Hrs. 8. Date of (Month, May			9. Birth	place (State (ntry)	or Foreign
	show		10a. State 10b. County			Town or Lo								10d. Inside	City Limits
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	with the Mi a or 28a-f	Dire	10e. Street and Number				10f. Zip C		4500		10g. C	itizen of W		ntry?	
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Viital	iician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:					6. Place of I	Death (Check only					
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Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place of In	jury - At home tc. <i>(Specify)</i>	, farm, stree	et, factory, o	ffice		28f. Location City or 7	(Street ar own, State	nd Number e)	or Aura	l Route Nun	nber,
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	4		30. Name and address of person who		death (Item 23	a) (Type, P	rint)	P	40	a Mar	n On	21_0	2	([3]	2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 1607 November Lee Rockwell Nancy 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2 🛛 Director 64 May 18, 1943 Maryland 220-40-0643 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 11 W Baltimore St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No þ Specify Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman E. Benner Mildred Louise Suffecool 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Turner/Sister 118 Alexander St. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 11/23/2007 | Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Thero **Physician** MINS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 : autopsy certificate 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA မ 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred After Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide

Division or Vital Records, or Attending Physician: within 24 hours arten co....

To the Funeral Director: Aft To the Hospital

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number

29b. Signature and title of certifier

determined

D283 65

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street Hages form 1902/740 308 OSHAPI. null

State Registrar

Medical

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4,2007 10:15 Dale Ernest Reynolds November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick College View Nursing Home Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Vest Virginia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min. 1√ M 2□ F 01/29/1936 West Director 236-56-3207 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Charles Town WV Jefferson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25414 United States "natural", or Itams 23a 104 Patrick Henry Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: δ White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steamship Agent <u>Baltimore Port</u> permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Importent: If item 27 Is marked other any injury or other traumatic svent, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Chester Luttrel Mary Moll Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 330 Rams Lane, Martinsburg, WV 25401 Stephanie Reynolds/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) /06/2007 Smithsburg Crematdrium Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 838, Funeral Home Charles Town <u>Homé</u> Jefferson Chapel Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on adjuline. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signad by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760%Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetel death Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manger of Death 28a. Date of Injury (Month, Day Year) Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29c. License number 29b. Signa re and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen She 31. Date filed (Month, Day, Year)

NOV 2 8 200

1- For Amend #5 Per State of Maryland / Department of Health and Mental Hygiene FH G874 12/05/07 Philipicate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:21 P M 10, 2007 November Rubin Evelyn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 15115 INTERLACHEN DRIVE #404 SILVER SPRING MONTGOMERY f Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Hours **Funeral** Days Min. Months 1 □ M 2√2 F 89 08/08/1918 MARYLAND **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☑Yes 2 ☐ No Funeral Director MARYLAND | MONTGOMERY SILVER SPRING 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20906 15115 INTERLACHEN DRIVE #404 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items dical Examiner mo 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 3 with and Mental Hygiene.
27 is marked other than "r traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORRIS RESSIN YETTA GOLDSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. Pages 1 and 2 9204 CRANFORD DRIVE, POTOMAC, MARYLAND NORMAN RUBIN - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State KING DAVID MEML GDNS 11/13/2007 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEARS ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ sign 1 be 1 Yes 2 No 3 Probably 4 Unknown ALZHEIMER'S DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1⊠Yes 2 No 1 🔲 Inpatient 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier D24543 NOVEMBER 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3305 NORTH LEISURE WORLD BLVD, SILVER SPRING, MARYLAND JAMES A ROSSI, MD 31. Date filed (Month, Day, Year) NOV 13 2007 32 Registrar's Signature State Registrar

J, Baitimore, Maryland 21215-0036		in and in and in the state of t	ci lic
ital necords, P.O. box 66/60,	an: The law requires that the death certificate be executed	tificate has been signed by the attending physician and	tor, page 2 should be detached for use as the burial-transit

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autopsy performed? Second	nanner as stated. , and due to the cause(s)
	ed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENEVIEVE WROBLEWSKI, M.D. 1355 PICCARD DR., #100, ROCKVILLE, MD.	MBER 14, 2007
State Registrar 31. Date filed (Month, Day, Year) NOV 1 5 20 07 State NOV 1 5 20 07	MBER 14, 2007 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2155 Rathkamp 09 200 7 Katherine /Medical acility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Solisbury egiona Wicomico Certi If Unde 24 Hrs. Birthplace (State or Foreign Country) 6/Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Min. 1 M 2 F Yrs. Director 06/21/1916 Mary Land 225-12-6632 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show other traumatic event, the Medical Exercitive must be nutified at 1 ☐ Yes 2 No Director MD Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a 21853 USA 33821 Ed Boston Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status o filed within 72 hours after do I Hygiene. Other than "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify. Year or Dates: 1943-45 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) t and 2 should be filed wi Health and Mental Hygien tem 27 Is marked other th Medical 12 Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Disharoon ဂ Dora Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is 33821 Ed Boston Road, Princess Anne, MD 21853 Gary Rathkamp/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 11/15/2007 Hurlock, Maryland Injury ^ 4 □ Donation 5 □ Other (Specify) 1. Signature of Funeral Service Licenses Hinman Funeral Home any M00295 11673 Somerset Ave, Princess Anne, MD 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acquired 4 hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 2/1 No 3 Probably 4 Unknown 1 Yes certificate has been si rector, page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ^L 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 / Homicide hin 24 hours a the Funerel D 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 0 29b. Signature and title of certifier D0059931 30. Name and address of person o comple ed cause of death (Item 23a) (Type, Print) MD Salisbury HOF 100 €

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

NOV 1 4 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiena 38054 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov **Physician** 25° 2007 11:10AM Charlotte Llewellyn Sigler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg

| Hunder | Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State U.) |
| Months | Days | Hours | Min. | Jan. 29,1926 | Maryland Allegany
9 Birthplace (State or Foreign Frostburg Village Nursing Care
5. Social Security Number 6. Sex 7. Age (In virs. last birthda **Funeral** 81 215-20-6241 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Expendent must be notified at 1 X Yes 2 □ No Director Allegany Frostburg MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 171 Washington Street 21532 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married White 1 Yes 2 No þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Education Teaching Supervisor s 1 and 2 should be filed v f Health and Mental Hygie item 27 le marked other t other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Buelah Willison Llewellyn Thomas Price Llewellyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train 171 Washington St., Frostburg, MD 21532 Charles Sigler husband Department of Hear Important: If Ite-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Xurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Mem Park11-28-2007Frostburg, MD 21. Signatur 1 Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, 4140 60 w. Main St., Frostburg, MD 21532 DWCIS M00547 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) URemis Physician menth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of) Examiner and I-transit Due to (or as a consequence of) sicien a Physician/Medical phys as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖼 No 3 Probably Be Completed ARTHRITIS with 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s TIC 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director. 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 F Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 125638 30. Name and address of person who completed cause of death (Item 2 a) (Type, Print)

On a sum alias a Completed Cause of death (Item 2 a) (Type, Print)

On a sum alias a Completed Cause of death (Item 2 a) (Type, Print)

On a sum alias a Completed Cause of death (Item 2 a) (Type, Print) Frostourg Mary Camp 21532 32. Registrar's Signature 31. Date filed (Month; Day, Year) NOV 2 Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** November 19,2007 Smikes Gwendolyn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 319 ple Hills If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 XF 252-90-8544 Director June 18,195B Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County works, r 28a-f show notified at Yes 2 No Director MD. Temple Hills PG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or dical Examiner must be r 2900 St. Clair Drive 20748 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black ð 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the Administrative Manager Credit Union permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other in injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmett Smikes Ardell Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5338 Haras Place Fort Washington, Keidra Dewberry/daughter Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 11/24/07 Mt. Zetella, GA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. any ir 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Heart Dis case **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Justo (or as a consequence of) Examine physician and the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 certificate I 2 No 2 12110 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 des 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural

P.O. Box 68760, Records, Division or Vital After this To the Hospital or Attending within 24 hours after death. To the Funeral Director: A

Maryland 21215-0036

Baltimore,

filled in by

Certification: 2 Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State

Registrar

00/

6 ☐ Could not be

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year) NOV 2 8 32. Registrar's Signatur

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

07-08651 Donte David Segar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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S	s 1 and 2 shou of Health and M If item 27 is n		20a, Method of	SEGAR	/ M	TILLI	12	20b. Place	of Dispos	sition (Name	of cem	etery,		Date	20c.	Location	- City or	Town, State
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Ralfimore	populit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pepmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f 8ho injury or other traumatic event, the Medical Examiner must be notified at once.		21 (Signature of	Funeral Servi	celLicens	see O	Λ		22.1	Name and A IARSHA 308 S	ddress	of Facility	FRΔT	HOME	OF.	MARY	LAND	. INC.
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Directors have a stood the deathed for use as the build. The funeral Directors have 3 thought he defaulted for use as the build.		(Check only one)	1 Certifyin	ng Physi Examin	cian: To the	asis of examir	nowledge, lation and/	death oc	igation, in my	c. Licen	se numbe	ccurreu	at the time, o	29	d. Date s	igned (M	lonth, Day, Year)
	To the Hospital or A within 24 hours after To the Formal Direction of the formal Direction of the formal of the fo	completely filled in		Certifyin Medical	ng Physi Examin	cian: To the	asis of examir	nowledge, lation and/	death oc	igation, in my	c. Licen	n, death c	ccurreu	at the time, o	29	d. Date s		lonth, Day, Year)
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- AP	Divis To the Hospital or A within 24 hours after. To the Fineral Direct contacts the contact of the contacts of the contact	completely filled in	29b. Signatur (Check only one) 29b. Signatur 30. Name and Laron L	Certifyin Wedical	ertifier Ly beerson who	cian: To the er: On the brand many occupied of stant Me	asis of examir ner stated.	th (Item 23	/or investi	igation, in my	c. Licen	se numbe	er	at the time, t	29	d. Date s	igned (M	lonth, Day, Year)

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene ? For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Short George William November 15,2007 4:15 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1084 Bramly Drive Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ F Yrs. 214-14-6542 88 March 28,1919 Virginia Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show other then "natural", or Items 23a or 28a-f eho vent, the Medical Exercit at most be notified at 1X☐ Yes 2 ☐ No Washington Hagerstown Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1084 Bramly Drive 21742 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Lead Man Aircraft Mfg. of Health and Mental Hygie fitam 27 te marked other ir other traumatic event, <u>ir</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if item 27 is marked oth eny liqury or other traumatic event one: Be ၉ Claude Short Alice Carrie Keyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary L. Elia Daughter 1084 Bramly Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 11-19-07 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. K. noel 40 East Antietam Street, Hagerstown, Md. 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** COBJARY /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a consequence Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed C resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy certificete 2 No 2 No 1 Tyes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🗌 Yes 2**X**TNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Seath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel C To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who pempleted cause of death (Item 23a) (Type, Print) SH-4 Stephen L. Hatleberg M.D. 1110 Medical Campus Road, hagerstown, Maryland 21742 31. Date filed (Month, Day, Year) NOV 19 2007 32. Registrar's Signature State Registrar

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State	of Man	yland /	Department of	of Health	and Me	ntal Hy	giene	ZU	U

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Н	Discontinuit		1. Decedent's Name (First, Middle, Last,					2. Date of Death Month November	Tay Year 200	3. Time of Death
	Physicia /Medic	al -	Jeffrey Lynn 4a. Facility Name (If not institution, give			4h City Town of	Location of Death	November	4c. County of Deat	
	Examin	er	Saint Joseph Med			J. Jay, Tallin, J.	Towson		Baltimo	ore
	Funeral Director		5. Social Security Number 6. Sec		s. last birthday, 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 28		hplace (State or Foreign untry) aryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	Maryl	ţō	Maryland Washing	ton		Hagerst	own			1 ☐ Yes 2X☐ No
	ith the	Sirec	10e. Street and Number			10f. Zip Code	04740	10	g. Citizen of What Co	
	sath w	Funeral Director	360 Woodpoint A	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	21740	ecify Yes or No-	14. Race - Ame	S.A.
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at ODGE.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates:	0.0.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	Rican, etc.)	Black, White	
Z 1 3-003	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	edent's Usual Occup	ation during most of work	king 1	6b. Kind of Business/	Industry
717	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retired ess Opera			Printing	g Company
ם ס	iled I Hygi other	40	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
yland	Menta Menta arked	To B	Leonard Henry						lartin Swa:	
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (T)						City or Town, State, 2	
ည်	thealt	ŀ	Karen E. Swain -	20b.	. Place of Disp	osition (Name of omatory or other place		Date 2	own Mary 1 Oc. Location - City or	Town, State
Ē	Pages nent of nnt: If i		1		edar La	wn Mem. F	ark 11-		Hagerstow	
Бащтоге	ermit. Nepartn nporte ny inju	Ī	21. Signature of Funeral Service Licens	iee Z					Fiery Fund	
	00 = 0		23a, Part1, Enter the disease, or comp	plications that caused the de						yland 21742 Approximate
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	9						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Anoxic E		орациу				
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. Cardiore		ory Arrest				
	rted Insit	miner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Pneumoni	, ,					
5	execu an and rial-tra	Examin	resulting in death) Last	Due to (or as a conse	equence of):					
3876U,	icate be executed physician and s the burial-transit	dicai	(dCharcot-	Marie-1	ooth Dise	ease			
O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year
1 .	es than grand de de	δ Δ	Part II. Other significant conditions of	antributing to death but not r	resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	accouse contribute t	o the cause of death?
Records,	e law has b	Completed						24a. Was ar autops perform 1 Yes 2	prior to	utopsy findings available completion of cause of
Ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			100		th (Check only one	9)	
6	Physic this c	-T	1 Yes 2 Alo 27. Maniler of Death	Hospital: 1 Anpatient 2 28a. Date of Injury	ER/Outpate	ent 3 DOA			nce 6 Other (Spe w injury occurred	ecify)
0	nding Phith. Ith.: After this funeral	ation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)		Wo	rk?]Yes 2 □ No			
Division of Vital	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this cartific tely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - Al building, etc. (Spe	t home, farm, s ecity)	street, factory, office	=300)	28f. Location (St. City or Town	reet and Number or F , State)	lural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifying Ph (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam and manner stated.	knowledge, dea ination and/or	investigation, in my	opinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	To the Vithin 2 To the Complet	Σ	29b. Signature and title of certifier	PI	M.1) 29c. Licen.	se number 4034	2!	9d. Date signed (Mon	th, Day, Year) ^7
			30. Name and address of person who	completed cause of death (I	tem 23a) /Tun				11/3/	~/
51	47+1		Timothy Low M				, Maryla	nd 21204		
		ate rar	31. Date filed (Month Day Year)	32. Redistrar's Sig	gnature	Locate				

State of Maryland / Department of Health and Mental Hygiene 2007 38059 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 10, 2007 **Physician** Spiewak Lawrence 11:35A. M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3112 Gracefield Road, #PV118 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month Day, Year) Mar17,1922 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1X M 2 □ F 145-18-9522 85 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Marylan 28a-f show notified at 1 ☐Yes 2 X No Maryland Montgomery Silver Spring Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or death with 3112 Gracefield Road, #PV118 20904 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ante of Health and Mental Hygiene. In the state of Health and Tis marked other than "natural", or ite any or other traumatic event, the Medical Examine any or other traumatic event, the Medical Examine 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Framer pictures 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Spiewak Marie Bernstein ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Spiewak, wife 3112 Gracefield Rd., #PV118 Silver Spring, Md. 20904 permit. Pages 1 and:
Department of Health
Important: If Item 27:
any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Metropolitan Crematory 11/12/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End stage chronic obstructive pulmonary disease **Physician** /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed Depression burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Sick sinus syndrome IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an cate has t 2 No 1□ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XNo Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes ours after death.

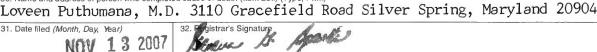
neral Director: /
filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month Day Year) November 12, 2007 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year) 2007 13 NOV



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D59524

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** November 11, 2007 Catherine Smith 2:00 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring
If Under 24 Hrs. Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct. 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖵 F 82 Yrs. Director 579-24-4323 1925 Washington, Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23 or 28a-f ahow any injury or other traumatic event. If a Medical Examinar must be notified anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Chesapeake Avenue 20910 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify:White 3x Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Leroy Posey Esther Alberta Souls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy W. Smith/ Son 706 Chesapeake Avenue, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 14, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Poplar Springs United 4 ☐ Donation 5 ☐ Other (Specify) 2007 Mt. Airy, Maryland Methodist Charch Cemetery 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring MD 20901 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ruptured Abdominal-Aortic Aneurysm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that is introduced.) Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypotension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2□ No 2 No 1 🗆 Yes 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 🗌 Pending I Director; A death. М 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20062 2007 NOV

State Registrar

31. Date filed (Month, Day, Year)

Kannarkat,

32. Régistrar's Signature

who completed cause of d



#121, Silver Spring, MD 20910

ath (Item 23a) (Type, Print) 16th Street,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{Year} November 10:07 PM Stella Schwartz 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 26, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min. New York 119-18-7154 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 Yes 2 No Bethesda Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 U. S. A. 5000 Battery Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3 V Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 2 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Podloff David Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Yale Avenue, Glen Echo, Maryland 20814 Leland J. Schwartz, Son 20a. Method of Disposition 1 ☐ Burial 2 Termation 3 Temporal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Alexandria, Virginia Metropolitan Crematory 11/7/07 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. Donald C 20852 1170 Rockville Pike, Rockville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration disease or condition resulting in death) Due to (or as a consequence of): Upper G I Bleed Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Post Operative Stress Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No Infected Right Hip S/P Removal & Placementof Spacer autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Napatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No

Examiner schwartz, Stella; 11/4/07; 1007pm burial-tran Division or Vital Records, P.O. Box 68760, physician the burial

Examine Physician/Medical Completed by certificate has the rector, page 2 s Be Certification; To filled in by the funeral after death.

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f shov dical Examiner must be notifled at

traumatic event, the Medical

al Hygiene.

Health em 27 i

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once,

Physician

/Medical

Baltimore, Maryland Ž1215-0036

Directo

Funeral

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Completed

Be

27. Manner of Death 28a. Date of Injury 28b Time of (Month, Day 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and fitte of certifie

29c. License number 032893

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR A. WOWK, MD. 8. #510 Rockville, MD 20852 6000 Executive Blud.

State Registrar

Medical

31. Date filed (Month, Day, Year)

NOV 13 2007



within 24 hours a

38062

		·	T = State Registrar			Cer	rtificate of l	Death		Reg. N	10. C U U	1 30002
			1. Decedent's Name (First, Midd	tle, Last)					2. Date Monti		Day Yea	3. Time of Death
	Physicia /Medic		Donald	Francis S	mith						10 200	
	Examin		4a. Facility Name (If not institution	on, give street and nu	ımber)		4b. City, Town, or	r Location o	of Death	4	4c. County of D	eath
			Frederi	ck Memori	al Hospi	tal	Frede	rick		l I	rederi	ck
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under :	24 Hrs. 8. Date	of Birth h, Day Yea	9.1	Birthplace (State or Foreign
	Director		577-16-0636	1 ∑ M 2□F	90	Yrs.	Wiotidio Bayo	l louis	Oct	.17,	1917	Wash D C
7	2		Usual Residence of Decedent		40. 00	Town and a						404 Incide Oiby Limite
-	show	-	10a. State 10b. Count	ederick	Toc. City	y, Town or Lo M	lletown					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
2	Ba-f s	cto	MD Fr	ederick		MIGC	ITECOMII					
4	or 24	Director	10e. Street and Number	D 1			10f. Zip Code	0176	0	10g. (Citizen of What	USA
-	23a ust t		3231 Bidle					2176				
-	tems er m	Funeral	11. Marital Status	Armed F	cedent Ever in U. orces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic On an, Mexicar	gin? (Specify Yes 1, Puerto Rican, et	or No- :.)	14. Hace - A Black, W	merican Indian, /hite, etc.
ရှိ ်	or i	by F	1 ☐ Never Married 2 ☐ Ma **XWidowed 4 ☐ Divorce	arried 1∐ Yes If Yes, G ed Year or D	2 ANo		1 □ Yes 2 No	Specify:			Specify:	White
3-003p	De lied within 72 hours after death with the Maryland tital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at			ent's Education	Dates.	16a Decer	dent's Usual Occup	ation		16h	Kind of Busine	es/Industry
2	n /2 ''na edic	Completed	(Specify only high	est grade completed,		(Give	kind of work done of DO NOT use retired	during mos.	t of working	1.00.	TAIL OF BOOM	oo maada y
7	e tiled within al Hygiene. other than " vent, the Mec	шc	Elementary/Secondary (0-12)	College 9	(1-4or 5+)		cehouse			n	rintin	19 00.
0	Hygin ther int, t		17. Father's Name (First, Middle	e, Last)			0110450		er's Name (First, M			
al	ould be Mental narked o	To Be	John C. Sm:	ith				Mabe	1 Lutz			
_ ,	should nd Men marke imatic	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address (Street	and Number	er or Rural Route f	lumber, Cit	y or Town, Stat	e, Zip Code)
200	alth ar 27 is 27 is		Susan LaLone	e (Daugh	ter)	305	Dellvil	lle R	d., Dur	cann	on, PA	17020
ย์ .	# # Fe		20a. Method of Pisposition		20b. F	Place of Dispo	sition (Name of	cel	Date	20c.	Location - City	or Town, State
2	rages nent of int: If its iry or o		1 Burial 2 XCremation 4 Denation 5 Other	3 ☐ Removal from	State Sm i	ithsbu	sition (Name of matory or other place irg Cran	ntory	11/13/0)7 Sm	ithsbu	irg, MD
Baitimor	- E 25 E -		21 Storeture of Funeral Service	1	-	24	Name and door	ss of Festion	yomp gon	Funo	rol Uc	\m_0
מ	Department on ce		(Much of	Wort	`		P. O. Bo	0×18	Niddl	etow	n. MD	21769
1	7		23a Part1. Enter the disease,	or complications that ist only one cause on	caused the deat						,	Approximate Interval Between
	huminiam		Immediate Cause (Final	st only one cause on	each line.	N 51	′ ′					Onset and Death
85	hysician /Medical		disease or condition resulting in death)	a	o (or as a conseq	uence of):	<u> </u>					
E	Examiner				(0. 40 4 0011004	9						
	٤.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to	o (or as a conseq	uence of):						
3	uted d ansit	Examiner	Cause (Disease or injury	1								
5	exec an an rial-tr	Exa	resulting in death) Last	Due to	o (or as a conseq	uence of):						
09/99	certificate be executed ding physician and ise as the burial-transit	/Medical		d								
0	tifica ng ph as th	led										
	endir use		IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna		Ectopic pregnancy	v			23d. Date of	
מ	deal e att	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of d		Other (specify)	,			Month	Day Year
5	w requires that the death been signed by the atter should be detached for u	Physicial	9 Unknown									
ś	gned gned	by F	Part II. Other significant condi	tions contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I	. 23e.			e to the cause of death?
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	pag ate	P							10	performed Yes 201	? deat	
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	ding Pr J. After th funeral		27. Manner of Death 1 X Natural 5 □ Pend		e of Injury onth, Day Year)	28b. Time o Injury	Wor			cribe how in	njury occurred	
IVISION	Attending r death. ector: After by the fune	atic	2 ☐ Accident inves	stigation				Yes 2				
<u> </u>	or At fter d Direct n by	Certification:		rmined 200, Flat	ce of injury - At he ding, etc. <i>(Specii</i>	ome, farm, sti <i>fy)</i>	reet, factory, office		28f. Loca City	tion (Street or Town, Si	t and Number o tate)	r Rural Route Number,
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- 3	ne Hospital or Attending 124 hours after death. The Funeral Director: A pletely filled in by the filled in	lical		ying Physician: To the al Examiner: On the								
	= = =	Medical	29b. Signature and title of certi		amer statett.		29c. Licens	se number	. 1	29d.	Date signed (IV	fonth, Day, Year)
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			30. Name and address of person	on who completed on	use of death (Itor	n 23a) /Tune					1 1	/
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 20b, perMD, g875, 1/16/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mey. 9, 2007 Month **Physician** 2007 1:45 James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Faith Assisted Living Knoxville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1127 M 2□ F Director 91 May 25, 1916 West Virginia 220-10-9234 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐Yes 2 No Director Knoxville Frederick Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 744 Jefferson Pike 21758 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 □ Never Married 2 N Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
Int: If Item 27 is marked other than Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Alonza Shriver Maude Lucretia Harper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy S. Virts / Daughter 744 Jefferson Pike Knoxville, Maryland 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State November injury or Department of Important: If any injury or 13, 2007 Lovettsville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Lovettsville Union Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1100 N. Maple Avenue Brunswick, Maryland 21716 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death a Part1. Enter the disease or complications that cars shock, or heart failure List only one cause on each Immediate Cause (Final **Physician** Olare disease or condition resulting in death) /Medical Due to (or a va consequent of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1□ Yes 2140 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Assisted 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 After this 27. Mannet of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Naturai 5 Pending To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HEGH CLIND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) coleren MO 21702 46B 10701 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2007 **NOV 15** Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Robert Clarence Street 07 36 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner eninsula Kegional Medical Center Salisburg (DICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Yea. 04/02/1913 9. Birthplace (State or Foreign Country) Maryland Social Security Number **Funeral** 1**X** M 2□F 212-03-0918 94 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No Director MD Somerset Princess Anne 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 11510 Somerset Avenue 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Owner/Operator Poultry & Grain Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If Item 27 is marked o any injury or other traumatic eve Clarence Berry Street Mary Briddell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Street, Jr./Son PO Box 203, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Andrews Episcopal 11/16/2007 Princess Anne, MD Signature of Funeral Service Licensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner law requires that the death certificate be executed schemic burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s certificate has 2 No Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 hpatient 2 ER/Outpatient 3 DOA ို this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier line, my 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) 100 E. CATION ST. Fernando Acle, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 14

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760,

ORIGINAL

Pages 1 and 2 should be filed within 72 hours after death with Baltimore, Maryland 21215-0036

	Phy /M Exa	si ec
	Exa	ım
Division or Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death	the Funeral Director: After this certificate has been signed by the attending physician and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2000 NOV 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rehabilitation Extended Care Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 1 X M 2 □ F Hours Director 220-32-4302 Nov. 4, 1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County at ral", or Items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 1728 Biggs Hwy. 21921 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 X Divorced Year or Dates: 1961-64 White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) r than the M Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Food Inspector Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 Is marked oth any lijury or other traumatic event once. Be Walter Smith Mary Atkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Jane Scott/Daughter Lafayette Ave., Palmerton, PA 18071 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11-14-2007 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signatu 22. Name and Address of Facility neral Service Licenses R. T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pticesui a e cian Kyown lical Due V (or as a consequence of) iner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an autopsy performed ↑
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fil (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, maryland 21218 3900 och Rayen Bouleversel M.D. Chn 32. Registrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 38066 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Anna C. Stephens 0450 November 11 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 544156416 WIRMIL REGIONAL MEDICAL ENINSULA If Under 1 Year | If Under 24 Mrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Hours 1 □ M 2 🛛 F 87 221-03-5068 Feb. 3, 1920 Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No MD Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 31959 Melson Road 21875 U.S.A. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sewell Henry Mitchell Stella May Riggin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth D. Stephens (Son) P.O. Box 5 Blanchard, PA 16826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Melson's Cemetery Nov. 14, 2007 Delmar, Maryland 22. Name and Address of Facility Short Funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 2 Probably 4 ☐ Unknown

Department of Heat. **Physician** /Medical Examiner

Physician

/Medical

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Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

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P.O. Box 68760,

Division or Vital Records.

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Examine the burial-transi physician Physician/Medical use ed by the a signed t this Jspital or. 4 hours after de∞. ∽ral Director: Atu

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listaber of Injur) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 3 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 4200 Completed W00 24a. Was an 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or / within 24 hours after - To the Funeral Dire completely filled in b P State

2007

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

(45049)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SNYdle MID 31. Date filed (Month, Day, Year)

NOV 13

29a. Certifier

(Check only one)

29b. Signature and title of certifier

100 East Carrol 32. Revistrar's Signature

and manner stated.

Salisbury Md

l 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Nov SOPHIA MAE SMULLEN 2007 0600 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prudail Salisbur Kehab & Nursing Ctr. Wicomico 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M % T 216-18-2114 Director 1921 MARYT AND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If them 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD WICOMICO MARDELA SPRINGS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11501 SAN DOMINGO RD 21837 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes → No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER FARMING 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ev HANDY DELMAR STANLEY ို IDA SHOCKLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 9853 SHARPTOWN RD MARDELA SPRINGS MD 21837 MELVIN SMULLEN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHARPTOWN ZION UMC 11-17-07 22. Name and Address of Facility
BENNIE SMITH FUNERAL HOME 917 W ISABELLA
STREET SALISBURY, MD 21801 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the complete the death. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 02 RM disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events nsequence of) Examiner The law requires that the death certificate be executed Ella attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 1 Yes 2 ER/Outpatient 3 DOA P 1 Inpatient this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred neral Director: After filled in by the funera Certification: To the Hospital or Attending within 24 hours after death.
-To the Funeral Director: After 1 ⊟-Natural 5 ☐ Pending investigation 1 Tes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Derrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

obing M. D 007 32 Supersignatur

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Mai	ryland / [Depa <i>Cen</i>	rtment tificate	of H	ealth a Death	nd M		iene	007	38068
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, if a Modical Examination invalue of Delified at ODGs.		20a. Method of Disposition		20b. Place o	f Dispos	sition (Nam	e of						or Town, State
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m	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti			Ectopic pre Other (spe						Month	Day Year
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Division of Vital Records,	l or Attending later death. Director: After	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	arm, stre	et, ractory	, опісе			City or Town	n, State)	realinger or	Hurar Houle (Vulliber,
_	spita tours neral		29a. Certifier Certifying Phy	sician: To the best of	my knowledge	e, death	occurred a	at the tim	ie, date and	d place, a	and due to the c	ause(s) a	nd manner	as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exami	ner: On the basis of e and manner state	examination ar	nd/or inv	estigation,	in my op	oinion, deat	h occurr	ed at the time, d	ate and p	lace, and d	ue to the cause(s)
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	An		30. Name and adves of person who co	impleted cause of dea	ath (Item 23a)	(Type, F	Print)							,
			Dr. Yogesh Vohra				e Dr.	, S	lisbu	ry,	MD 2180	14		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 11/10/2007 Doris B. Thorburn 3:58 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crescent Cities Nursing Home Riverdale Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Date of Birth (Month, Day, Year) 7/23/1929 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F Vrs 78 061-24-0081 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Marala Hygiena "ratural", or items 23a or 28a-f show Important: of item 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20879 USA 423 Christopher Avenue, #11 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒No Black Specify Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Cling Isadore Boags ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Thorburn - Daughter 3130 Wisconsin Ave NW #19, Washington, DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/13/07 Alexandria, Virginia 4 Dopration 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 M01491 Man 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) alignant **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should I Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2K No after death.

Director: After this certifications 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State NOV 1 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar AVEND#29dperMD1		ryland / Dep McCo <i>Ce</i>	artment			ind M		jiene	17	38070		
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	er ^{Bay} , 20	Year	3. Time of Death		
	/Medic	al	Constance Alice T			4h City	Town or	Location o	f Death	Novembe	er 8, Z		12:34A. [™]		
	Examin											nce George's			
	Funeral Director		Social Security Number 6. Sex		(In yrs. last birthday 78 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth Month, Day March2	7 [×] , 1929	9. Birthp Peni	lace (State or Foreign ISylvania		
240	D		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation							0d. Inside City Limits		
	e Maryla la-f eho	ctor	Maryland Prince Ge	orge's	College					·			1 Yes 2 No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic event, if a Medical Examinating any once.	al Dire	10e. Street and Number 9209 Wofford Lane								What Cour Stat				
036		by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, specifies it Yes, Sive Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specifies it Yes, Sive Year or Dates:					s Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Specify:					14. Race - American Indian, Black, White, etc. White		
121		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5	+) (Give	edent's Usua e kind of woi DO NOT us tered	rk done d se retired	turing most)	of worki	ng	Prince Hospit	Geoi	ge's		
land 2		To Be Co	17. Father's Name (First, Middle, Last) Peter Zalonis, Sr.		11.0850			18. Mothe		(First, Middle, Savage	Maiden Suman				
Mary			19a. Informant's Name/Relationship (Type Francis G. Tracy -h	oe, Print) Susband	19b. Mai 9209	Woff	(Street a	Lane (coll	Route Numbe ege Par	k, Md.	2074	Code)		
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State		Heave	en C	emete:	ry 1			er Sp	own, State oring, Md.		
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	ngera	- F 10 4	onald 400 Po	owde:	Borgw r Mil	ardt 1 Ro	Funera ad Belt	l Home, sville,	PA Mary	land 20 7 05		
	The law requires that the death certificate be executed X W W W W W W W W W W W W	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if airy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Interval Between Onset and Death		
P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Fetal death 3 Ectopic pregnancy						23d. Date ol delivery Month Day Year				
rds, P.		ρ	Part II. Other significant conditions con Gastrointestinal I			underlying c	ause give	en in Part I.			obacco use conf es 2 □ No		he cause of death?		
Œ		Completed						perfor	a. Was an autopsy performed? Yes 2 XNo 24b. Were autopsy lindings available prior to completion of cause of death? 1 Yes 2 No						
Vital	Physicien: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	ospital: 🚜			Oth	or.		(Check only o					
of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date ol Injury (Month, Day Year) 28b. Time of Injury Injury M 1 Yes 2 No						lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
Division		Certification:	3 Suicide 6 Could not be determined						28I. Location (Street and Number or Rural Route Number, City or Town, State)						
		Medical (
	20 girting	Ž	29b. Signature and title of certifier	ИD			D609	e number 136		S	29d. Date signe	d (Month	⁹ 4 ⁹ , ⁷ 2007		
			30. Name and address of person who co Abdul Momin Tak, N				ומינון	Mar	v1an	d 20707					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 3 200	32 April edistr	ar's Signature			, 1101	yran	20/0/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 17 3807 For Full 17 Per INF 11/15/07, FMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 10, Tavitian p M Honaria 2007 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 7, 19 Birthplace (State or Foreign Country) **Funeral** 1 M 2K F 218-66-7360 Director 81 1926 Greece Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 XXXIo Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 15211 Elkridge Way, #2E 20906 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Garment Manufacturing 17. Father's Name (First, Middle, Last) Nishan Sarakian David A. Tavitian 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental ! Imastouhi Manoukian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Dourian/Daughter 8500 Wild Olive Drive, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 14. 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiany **Physician** *lean* disease or condition resulting in death) /Medical Examiner orang Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as t IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 27. Manne of Death 1 Natural funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 2

> State Registrar

31. Date filed (Month, Day, Year)

13 2007 NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAND M. BRILL UND

136601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Marie Mary Tarleton Nov. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Eacility Name (If not institution, give street and number) Examiner Wicamico Salisbury Kegional Medical Center If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 01/21/1921 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Months Days 1□M 2K0F Virginia 86 Director 220-26-3463 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Exception 1. 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 □ No Director Princess Anne Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21853 IISA 11210 Old Princess Anne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: δ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shirt Factory 12 none Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenny Black John Williams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Inez Tarleton/Daughter 11210 Old Princess Anne Road, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Rock Creek Cemetery 11/11/2007 Chance, Maryland 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ESOppageal Canco Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed the burial-tra Due to (or as a consequence of): physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed certificate Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA Certification: To 1 / Inpatient After this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending

P.O. Box 68760 Division or Vital Records,

r death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Leccesson M

11-9-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARROLL Street Salisbury Md 21801 100€ MU

5 ☐ Pending investigation

6 ☐ Could not be

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Terry Marlian Tjiong 2007 November 8 11:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince Georges 8. Date of Birth (Month, Day, Year)
Oct. 13, 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 💢 F Hours Director 1928 Indonésia 218-27-3100 filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Charles White Plains 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4900 Crain Highway 20695 ISA 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify:Chinese Be Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Lu Wie Tjiong Kim Moy Gow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tek Siang Tjione/ Son 4900 Crain Highway, White Plains, Maryland, 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any Injury or oth Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity MemorialGdns: 11-12-2007 Waldorf, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 3035 Old Washington Road Waldorf, Maryland, 20601 - Willyon Huntt Funeral Home Wack M01246 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE CORONARY SYMDROME. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FIBRILATIONI. VENTRICHLAR Sequentially list conditions, Due to (or as a consequence of) Examiner h any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ohysiclan and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ + 4 DERTENIION 1 Yes 2 No 3 Probably 4 ™nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No LIPID DISORDEZ 24a. Was an page 2 s autopsy certificate 1∏ Yes 2 **2** No or Attending Physician: the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Yes 2 No 2 R/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Aatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical соmpletely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K. Maleyin - mo D50689 111081 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) ANILIC MATA AT ANIMD

DB 7

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 3 2007

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32. Registrar's Signature

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CLINIVN

		For State Registrar 1. Decedent's Name (First, Middle, Last)	Seberina	Ventu			Re 2. Date of Death Month	3	3807 3. Time of Death
Physicia /Medic Examin	al	Severine 4a. Facility Name (If not institution, give s	treet and number)	Ventura		Location of Death	November 6	4c. County of Deat	
Funeral Director		5/9-/2-98/8	7. Age (In.	yrs. last birthday) Ó Yrs.	Silver Sp if Under 1 Year Months Days	ring If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 8, 1	Montgom 9. Birt 911	ery thplace (State or Forei puntry) Peru
show d at	_	Usual Residence of Decedent 10a. State 10b. County		. City, Town or Lo					10d. Inside City Limi
Mental Hygiene. arked other than "natural", or items 23a or 28a-f show attc event, the Medical Examiner must be notified at	Direc	Maryland Montgomery 10e. Street and Number 12023 Dalewood Drive		Silver Spr	ing 10f. Zip Code 20902		10	g. Citizen of What Co	
Department of Health and Mental Hygiene. Instural, or items 23a or 28a-f show Important: If item 27 Is marked other than "natural," or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I		2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2♣4No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto Specify: Peru		14. Race - Ame Black, Whit Specify: Hi	e, etc.
ene. than "natura he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 5th	cation completed) College (1-4or 5+)	(Give life, L	dent's Usual Occup kind of work done OO NOT use retired emaker	ation during most of worki i)		6b. Kind of Business	/Industry Home
ental Hygi ked other c event, t	To Be Co	17. Father's Name (First, Middle, Last) Nicanor Ventur	ra			18. Mother's Name	. 73	faiden Surname) mi	
Iffin and Ivin	Ë.	19a. Informant's Name/Relationship (Type Yolanda Salazar / Daug		1	•	and Number or Run		City or Town, State, .	Zip Code)
nent of Hea int: If item 2 iry or other	i	20a. Method of Disposition 1 Herical 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	ob. Place of Dispo cemetery, crer esurrection	sition (Name of matory or other place n Cemetery	ce) 11/17/	2007	Clinton, Ma	ryland
Departri Imports any Inju		21. Signature Funeral Service License	las In		6160 Oxon H	ill Road Ox	on Hill, M		me PA 1745
ysician Medical caminer	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) S. uentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ASPIRAT. Due to (or as a cor	ION PNEUM nsequence of): AILURE TO	ONIA	ng, such as cardiac	or respiratory arre	rst,	Approximate Interval Between Onset and Death 3 weeks 3 months
been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	Due to (or as a col	regnancy Fetal death 3 E	□Ectopic pregnanc: □ Other (specify)	у		elivery Day Year	
signed by	by	Part II. Other significant conditions cor Hypothyro		t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	oacco use contribute t es 2 X No 3 ☐ P	o the cause of death robably 4 □Unkn
ate has page 2	Completed	Dysphagia					24a. Was a autops perforr 1□ Yes	y prior to	
within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	28d, Describe ho	ence 6 Other (Spanish injury occurred area and Number or F					
24 hours afte Funeral Dir stely filled in		29a. Certifier 1 Certifying Physic (Check only) 2 Medical Exami	building, etc. (S sician: To the best of m ner: On the basis of exa	y knowledge, deat			and due to the c	ause(s) and manner a	
within 24 To the F complete	Medical		and manner stated.		D	se number 5485	2	9d. Date signed (Mon	
(3)		30. Name and address of person who co Barbara Supanich	MD 1500 Fore	(Item 23a) (Type, est Glen Ro	Print) pad Silver S	Spring, Mary	and 209	10	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland		artment rtificate			and M	ental Hy	giene Reg. No.'	2007	380	75
()	Physici		1. Decedent's Name (First, Middle, La Leighton David		ns						2. Date of De Month Noverni	eath	9, 200	3. Time of De 7 5:55 I	eath
	/Medic Examin		4a. Facility Name (If not institution, giv 427 Chestnut Dri	e street and number)			4b. City, 1		Location o			4c. (County of Dea		
	Funeral Director		5. Social Security Number 6. S 579–32–8727	53.	ge (In yrs. Ias 78	t birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da 04/08)	rth ay, Yea <i>r)</i> 1929	9. Bir C Ind	thplace (State or Fountry) iana	oreign
	Maryland -f show ied at	tor	Usual Residence of Decedent		10c. City,	Town or Lo	cation							10d. Inside City I	
	3a or 28a st be notif	l Director	10e. Street and Number 427 Chestnut Dri	.ve			10f. Zip						en of What C		
730	be filed within 72 hours after death with the Maryland that Hygiene. Ind other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 21 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		I4. Race - Ame Black, Whi Specify:		
1215-0036	"na edio	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	(Give life. I	dent's Usua kind of wor DO NOT us Cronic	k done d e retired	luring most)		ng		of Business Govern		
land 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last Leighton Earl Wi			DICC	or on re			r's Name	(First, Middle				
, mary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Margaret E. Will			427	Chest	tnut	Driv	e, L	usby,	Maryl	Town, State, and 20	657	
saitimore	permit. Pages 1 and 2 Department of Health s Important: If Item 27 Is any Injury or other tra		20a. Method of Disposition 1											aryland	
ñ	Dep Imp		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause	d the death.	Do not ent				, Lu	sby, M	ary1a		Approximate	
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li a. LUN Due to (or as	9 ca	nce								Interval Betwe Onset and Dea	en ath
から	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as											
.U. BOX 68/	death certif		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 🗆 Fetal d	leath 3	□Ectopic pro □ Other (sp					2	3d. Date of de Month	elivery Day Yea	ar
7	requires that the een signed by th nould be detache	by Physician/M	Part II. Other significant conditions	contributing to death t	out not resulti	ing in the u	nderlying ca	ause give	en in Part I.				se contribute t	to the cause of dea	
II Kecords,	The law ate has b page 2 sł	Completed											24b. Were a prior to death?		ailable se of
VITa	siclan: certifica rector,	Be	25. Was case referred to medical examiner?	Ltanital:				1011		of Death	(Check only	one)			
0	ding Phy I. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	ent 2 ☐ EF ury 2 ay Year) 2	R/Outpatier 8b. Time o Injury		8c. Injun Work	4 ∐ Nu	- 1	me 5 Res 28d. Describe		Other (Sp.	ecify)	
DIVISION	al or Attending s after death. al Director; After ed in by the fune	Certification:	3 Suicide 6 Could not b	e 28e. Place of in	jury - At hom tc. (Specify)	e, farm, str	reet, factory					(Street and own, State,		Bural Route Numbe	er,
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	Medical (nysician: To the best miner: On the basis of and manner st	of examination		vestigation	, in my o	pinion, dea						
	Tot withi Totl	Ž	29b. Signature and title of certifier	col MD)				906	1				th, Day, Year)	07
	10		30. Name and address of person who	completed cause of a	death (Item 2	3a) (Type,	Print) 212	f	princ	e F	reder	rick	MD	2067	8

State Registrar

DHMH 17 Rev 1/2001

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

NOV 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 4:00 A M JOHN W. WALES November 19, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9/26/1922 Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 □XM 2 □ F Pennsýlvania Director 163-24-8220 Usual Residence of Decedent 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director PA York Delta 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17314 202 Parke Avenue USA "natural", or items 23a by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Person Agricultural Chemicals 8 injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Steele Gibney Hugh Wales ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Emma O. Wales/Wife 202 Parke Avenue, Delta, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Susquehanna Mem.Gdns 11/23/07 York, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any Harkins Funeral Home, Inc., Delta, PA and a support of the disease, or complications that caused the dearn Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final Physician OS, S disease or condition resulting in death) /Medical Due (of as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examine Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 200 1 ☐ Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes ∠ No 24a. Was an certificate has funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: inpatient 1 Yes / No 2 ER/Outpatient 3 DOA ပ After this 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director; the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Values John M800482953 Division or Vital Records, P.O. Box 68760,

Medical

State Registrar 29b. Signature and title of certifier

29c. License number

hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Tokkradow,

chesapeake Dr., Belair, MD 21014

31. Date filed (Month, Day, Year)

(Check only one)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yea **Physician** JAMES WILLIAMS 10 2007 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number, Examiner Plata Medica a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days XXM 2□F 1939 GEORGIA DEC. 11, Director 260 64 5798 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r 28a-f show notified at XX Yes 2 No Director WHITE PLAINS MD CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ber UNITED STATES ns 23a must b 20695 4210 SOUTHWINDS PLACE #115 death \ Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Specify: BLACK ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b, Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE LABORER **PEPCO** 12TH marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MATTIE (UNKNOWN) JOHN HENRY WILLIAMS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 00 4210 SOUTHWINDS PLACE #115 WHITE PLAINS, MD 20695 VIOLA WILLIAMS / WIFE Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 11/15/2007 CLINTON, MD 4 □ Donation 5 □ Other (Specify) 21. Signalure of internal service Licensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Pal . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Atheroscieratic Heart Disease. Immediate Cause (Final disease r condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Dubeter Mellitus Years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown signed b d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð SHOKE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this funeral 27. Manner of Death 1 M.Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation o the Hospital or Attendin thin 24 hours after death. The Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R. Sindua november 11,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder Sindhumi MP 11350 Pembrook Sq Suite 304 Waldorf, MO 20603

State Registrar

Registrar

State

ATE

7700 OLD Branch

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERWA

4AXMI

31. Date filed (Month, Day, Year)

NOV 1 3 2007

31. Date filed (Month, Day, Year)

30. Name.

29b. Signature and title of certifier



M

cause of death (Item 23a) (Type, Print)

90

Registrar

29d. Date signed (Mbnth, Day, Year)

	•		101	partment of Health and Meertificate of Death	ental Hygiene	7 39091
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Ingeborg E.	Weiss	November 9, 2007	9:30 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	
			12511 Haxall Court	Ft. Washington	Prince	George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 1 ☐ M 2 ☑ F 85 Yrs	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Year April 13, 1922	Birthplece (State or Foreign Country) Germany
	P .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Logation		10d. Inside City Limits
	ehow	5		shington		1 ☐ Yes 2 No
	the N	ect	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	
	With with	ă	12511 Haxall Court	20744	USA	ias Country:
	leath	era		Was Decedent of Hispanic Origin? (Spe		- American Indian,
36	ges 1 end 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f ehow or other treumatic event, the Medical Examiner must be notified at	by Funeral Director	Armed Forces? 1 Never Married 2 Married I Yes 2 Amol	If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑NO Specify:	Rican, etc.) Black,	, White, etc. White
21215-0036	hour tural	g p	3€ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation		
5	in 72	Completed	(Specify only highest grade completed) (G	cedent's Osual Occupation ive kind of work done during most of working. DO NOT use retired)	16b. Kind of Bus	iness/industry
72	with iene. r ther	E	Elementary/Secondary (0-12) College (1-4or 5+)	lical Secretary	Hospital	
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Men	ToB	Gustav O. Scholz	Marie	Utech	
lan	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rura	l Route Number, City or Town, S	tate, Zip Code)
	end sealth m 27			l1 Haxal1 Court Ft. Washi		20744
ore	Pages 1 nent of H int: If Ite		1 Burial 2XXCremation 3 Removal from State cemetery,	rematory or other place)		City or Town, State
Ë	Pag tment tent: jury o		4 □ Donation 5 □ Other (Specify) Kalas Cr			, Maryland
Baltimore,	permit. Pages 1 end 2 Department of Health s Importent: If Item 27 is eny Injury or other tre 900.		21. Signature of Fune at Pervice Licensee	22. Name and Address of Facility Geo 6160 Oxon Hill Road Oxor		al Home PA 20745
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each time.	enter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	ATIENOSCLER		Onset and Death
	/Medical		resulting in death) a Due to (or as a consequence of):		31-3	1
Е	Examiner		Sequentially list conditions, b.			
	p tis	Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury			
	and I-tran	хаш	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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687	icate phys s the	dicat	d.			
Box (leath certific attending p I for use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. # yes, outcome of pregnancy		23d. Date	of delivery
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	in the past 12 months? 1 Yes 2 Mi No 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>	Mont	
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	es tha igned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?
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Records,	faw fas be	Completed			autopsy pri	ere autopsy findings available ior to completion of cause of
E E		S				ath? ☐Yes 2☐No
Vital	Physician: this certific rat director,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
to	Phys this rat dir	T.	1		ne 5 Ka Residence 6 □Other	
	ding After fune	ri G	122Natural 5 ☐ Pending (Month, Day Year) Inju		28d. Describe how injury occurred	o .
Division	deat deat stor:	ficat	3 Suicide 6 Could not be age Block of lainty. At home to		28f. Location (Street and Number	r or Rural Route Number
<u>S</u>	를 를 들	Certification;	4 Homicide determined building, etc. (Specify)	Street, lastery, office	City or Town, State)	
	Hospital 24 hours a Funeral tely filled		29a. Certifier Cartifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place, a	and due to the cause(s) and man	ner as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) and manner stated	investigation, in my opinion, death occurre	ed at the time, date and place, an	nd due to the cause(s)
	To To Com	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
•		/	Jun Dury Col	1) 1) 2060	7 111	12/0/
R	. (10)		30. Name and address of person who completed cause of death (Item 23a) (Ty	B. Print) WAC	DONF W	10 20603
-	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 3 2007 32. Registrar's Signature			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician NOVEMBER 06, 2007 FLORNIA JEAN WEATHERBY 5:35P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9916 STONEWOOD COURT PRINCE GEORGES UPPER MARLBORO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XXF 14, 1941 Director 579 54 2288 FEB. VIRĞINIA 66 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10h. County 10d, Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes XX No Director MD PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? 9916 STONEWOOD COURT 20772 UNITED STATES Funeral Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married XXMarried altimore, Maryland 21215-0036 ō 1 ☐ Yes XX No Specify Completed by Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CALAFORNIA STATE Elementary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Pages 1 and 2 should be f nent of Health and Mental ! int: If Item 27 is marked of 2 WILLLIAM WILSON EMMA TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) IRA WATHERBY / HUSBAND 2462 LECCO WAY MERCED, CA 95340 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 11/13/2007 BRENTWOOD, MD 21. Signature of Euneral Service Licens 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedite Cause (Final **Physician** CARDIOPULMONARY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CARDIOMYOPATHY Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mon 1 Yes 2XXVo 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) P.O. as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy page perforn certificate 1□ Yes XX No or Attending Physician: rector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home XX Residence 6 Other (Specify) Ŷ. XIX Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation (Month, Day Year) 1X Natural Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident efter deaf 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eff To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 Cc 007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5801 ALLENTOWN RD. CAMP SPRINGS, MD 20741 DAVID T. ISAACS, MD 31. Date filed (Month. Dav. Year) 32. Registrar's Signature State NOV 1 3 2007 Registrar

DHMH 17 Rev 1/2001

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			For State	State of Marylar				i Mentai Hy	^{'glene} 20 (07 38083		
			1 - State Registrar	24)	Ce	runcate	of Death	2. Date of De	Reg. No.	10.7		
	Physici	an	Decedent's Name (First, Middle, Las					Month	Day Y	3. Time of Death		
	/Medic		Margaret Beatri 4a. Facility Name (If not institution, give			4h City Tou	vn, or Location of Dea		er 9, 200 4c. County of			
	Examin	er	Southern Maryland					auı	·			
	Funeral	_	5. Social Security Number 6. Se	<u> </u>	. last birthday)	Clir If Under 1 Y				e George's Birthplace (State or Foreign Country)		
Ш	Director		579-58-5244	□M 21€7 F 80	Yrs.	Months Da	ays Hours Mi	n. (Month, Da April		Rockville, MD		
	P.		Usual Residence of Decedent					14.02.22				
	arylar show dat	_	10a. State 10b. County Maryland Prince 0		ity, Town or Lo		1			10d. Inside City Limits		
	.8a-f	Director		eorge s	Сартс	ol Heig				1 TyyYes 2 □ No		
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Β̈́	10e. Street and Number			10f. Zip Co			10g. Citizen of Wha			
	eath	Funeral	904 Logwood Road	1 12. Was Decedent Ever in U	15 13	207		/Specify Vos or No		d States American Indian,		
	ter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	J.G. 13.	If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	erto Rican, etc.)	Black,	White, etc.		
336	al", or	by	3 → Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐	No Specify:		Specify:	Black		
ŏ	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual O	ccupation		16b. Kind of Busir			
21215-0036	e. an "r Med	ed ((Specify only highest grad	College (1-4or 5+)	life.	DO NOT use re	one during most of w etired)	vorking	1			
	ed wil	Completed	12 years			Nurse				vate		
D L	be fill d oth even	Be	17. Father's Name (First, Middle, Last)						e, Maiden Surname)			
Z	i Mer I Mer narke	ပ္	Eugene H. Green					Diggs				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7) Trudy Marcell Mil		1				ber, City or Town, Sta ights, MD			
	1 an Healt em 2		20a. Method of Disposition			osition (Name of matory or other		Date	20c. Location - Cit			
altimore,	Pages nent of h ant: If Ite		1 ☐Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					4 2007		on, Virginia		
ቜ	nit. Partme ortan injur		21. Signature of Funera Service Linn						uneral Ho			
m	permi Depa Impo any i		1. Kanas	Ads. D.					hington,			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the dea						Approximate		
	Physician		Immediate Cause (Final disease or condition	ne cause on each line.	Ven.	0 %.	0/1	Leve	£013:	Interval Between Onserland Death		
	/Medical		resulting in death)	a. Due to (or as a conver	quence of):	FIN	35			3100		
	Examiner		Sequentially list conditions	b			ı					
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):							
	ecute and -trans	am	that initiated events resulting in death) Last	c								
90	te be executed ysician and e burial-transit	cal E		Due to (or as a consec	quence oi).							
687	eath certificate be executed attending physician and for use as the burial-transit			.d				711				
ŏ	certif nding use as	NA I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn	nancy				23d. Date of	of dollyon.		
ă	death atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		∃Ectopic pregn ∃Other (specif			Month			
0	t the oy the archec	Physician/Med	9 □ Unknown	9□Unknown								
ď.	The law requires that the death certifica tte has been signed by the attending phy page 2 should be detached for use as th	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Records,	equire en sig ould b	ed b						1 0	Yes 2 No 3	☐ Probably 4 ☐ Unknown		
ဝင္ပ	ne law re has ber je 2 sho	Completed	24a. Was an 24b. Were a									
		E						- auto perfe	ormed? dea	or to completion of cause of ath?]Yes 2∐ No		
Vital	slcian: The certificate ha rector, page	Be	25. Was case referred to medical examiner?				26. Place of D	eath Check onl				
	S 50 10	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resi	idence 6 □Other	(Specify)		
ū	ding Ph h. After thi funeral		27. May ner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?	28d. Describe	how injury occurred			
Sio	tend leath. tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ No					
Division or	or At after d Direc in by	Certification:	4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ify)	eet, ractory, of	ice	281. Location (City or To	(Street and Number own, State)	or Rural Route Number,		
_	e Hospital or Attenc 24 hours after death 9 Funeral Director: etely filled in by the		29a. Certifier 1 Certifying Phy	ysician: To the best of my kn	owledge deat	h occurred at th	ne time, date and ple	ice, and due to the	cause(s) and monn	per as stated		
	the Hospital or nin 24 hours afte the Funeral Dir npletely filled in I	Medical	(Check only 2 Medical Exam	niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in	my opinion, death oc	courred at the time	, date and place, and	d due to the cause(s)		
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	_		29c. Lic	cense number		29d. Date signed (/	Month, Day, Year)		

11.0907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAXMI BETWAMD 770D OID BRANCH AVE. Clinton, Md 20735

31. Date filed (Month, Day, Year)

NOV 1 3 2007

Agriculture

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** November 10, 3:25 MG Wilma Davis Woodard 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Springvale Terrace Assisted Living If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1 M 2 S F Aug. 15, 1908 Director Indiana 315-16-1441 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a State 10h County 1 Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with "natural", or Items 23a or 20901 USA 9907 Merwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 72 hours after 2**⊠X**io 1 ☐ Yes 2 점 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White Ş 3 Widowed 4 □ Divorced and 2 should be filed within 72 hou alth and Mental Hygiene.
27 is marked other than "natura er traumatic event, the Medical E. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Davis Anabele Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9907 Merwood Lane, Silver Spring, MD 20901 Mark D. Woodard/Son Item 27 i Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Department of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 Removal from State 14, Nov. Scottsburg Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Scottsburg, Indiana 21. Signatur 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final **Physician** 20 Years Heart Disease disease or condition resulting in death) Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed anding physician and use as the burial-trar Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 🗔 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be o þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specific Stated 2 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Living Facility 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. 1 Division or Vital Records, To the Hospital or Attending Physician:

Saltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the

29a. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Day, Year)

NOV

13

2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D12121

November 12, 2007

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

George F. Sengstack, MD 3939 Ferrara Drive, Wheaton, MD 20902

State Registrar



07-08476 Ben Mark Wells

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1, Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2007 Year 2150 hrs Medical Examiner Wells Ben Mark II 4b. City, Town, or Location of Death 1c. County of Death 4a. Facility Name (if not institution, give street and number Wicomico Powellville Laws Road South of Mount Hermon Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Foreign Months Days Hours Min 218-27-7232 Maryland Director 17 Yrs 01/15/1990 2 F 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 3u 10a. State 1 X Yes 2 No 23a or 28a-f show notified at once. Maryland Wicomico Willards the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21874 7218 Lewis Lane 14. Race - American Indian, Black, death with 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantai Status Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. or items Armed Forces' 1 XNever Married 2 Yes 2 X No Specify: Yes 2 X No specify. white Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. If Yes, Give Year Widowed Divorced is marked other than "natural", on the event, the Medical Examiner ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) umemployed 10 0 n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ben Mark Wells, Sr. Debbie Lynn Parsons Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7218 Lewis Lane, Willards, MD 21874 nt: If item 27 is other trauniat Debbie L. Lewis/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/5/07 New Hope Cemetery Willards, MD tant: Donation 5 Other Specify. 22 Name 581 re and Address of Facilit LOWAY Fune I Snow Hill uneral H Home Professional Association , Salisbury, MD 21804 94. Hompson Approximate Interva 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death 'Medical a. Head Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical physician a AMENDED UNPENDED 23d. Date of delivery Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Year Day Month 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Linknown 23e. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available Completed 24a. Was an icate has been s page 2 should ! prior to completion of cause of autopsy death? performed? 2 No Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) Hospital or Attending Physician: ' 24 hours after death. 25. Was case referred to medica ector, 8 Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Other [DOA Inpatient 2 ER/Outpatient 3 After this 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Oct 31, 2007 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Driver auto fixed object collision Certification: 2052 hrs Yes 2 V No Natural Pending Director: d in by the f Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Laws Road near Mount Hermon Road, Poweliville, MD Could not be Suicide within 24 hours at To the Funeral L determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 1, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

Registra

111 Penn Street, Baltimore, MD 21201

istrar's Signature

SUL.

Chief Medical Examiner

OCME

6 2007

David Fowler M.D. 31. Date filed (Month, Day, Yea

State of Maryland / Department of Health and Mental Hygiene

For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Lams 1010 200 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner MICOMICO 15 DUV bostal 0) the -ake Hospice If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 K F 83 Director 215-20-4723 8/27/1924 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Wicomico Maryland Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 6117 Tarry Town Rd. 21801 or itams 23a USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white If Yes, Give Year or Dates: ģ 3 X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker domestic permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Daniel Robinson Lula A. Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gayle L. Williams/daughter 27585 Pemberton Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Parsons Cemetery 11/10/07 Salisbury, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician CARGNOMA OF MOUTH /Medical Due to (or as a consequence of): **Examiner** YMPHOWA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) Ö the detached 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 94No Division of Vital Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 2 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Dale of Injury (Month, Day Yeer) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After II completely filled in by the funera 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. ical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 1733 SHUISBURY UND 2/802 COASTAL HOSPICE -Hayany WARLS 31. Date filed (Month, Day, Year) State NOV 09 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Maryland	d / Depa <i>Cer</i>	rtment of Hea	ith and Me		giene 0 0 7	38087
			Registrar 1. Decedent's Name (First, Middle, Last)		301			. Date of Dea	th	3. Time of Death
	Physicia		DEBORAH 1	HIENCKO:	SKI			Month	Day Yes	7 10:25 M
	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, or Loc	eation of Death		4c. County of D	
			COASTAL HOS	PICE ATTHEL	AKE	SACISB				MICO
	Funeral		5. Social Security Number 6. Sex	11 0000	last birthday) Yrs.	If Under 1 Year If I Months Days H	ours Min	Month, Day	(Year)	Birthplace (State or Foreign Country)
ja.	Director		143-54-2826	^M ² X ² 50	YTS.			8/25/1	957 N	ew Jersey
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ō	Maryland Wicomico	Fr	cuitlar	nd				1 ☑ Yes 2 ☐ No
	the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	h with	O	194 Nina Lane			21826			USA	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - A Bleck, W	merican Indian, /hite, etc.
36	or the	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		_	pecify:		Specify:	white
Ö	hours tural'	d by	3 Widowed 4 Divorced	Year or Dates:	16a Decec	ent's Usual Occupation	1		16b, Kind of Busine	
7	n 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done durin OO NOT use retired)	ng most of working	,		·
72	With liene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Admini	strative A	ssistant		Real Es	tate
ַב	othe othe	BeC	17. Father's Name (First, Middle, Last)			18.	Mother's Name (First, Middle,	Maiden Sumame)	
lar	uld by Menta Virked Irked	To E	Thomas Nufrio				Elaine			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pyglene. Important: if item 27 is marked other than *natural', or items 23a or 28a-f show any injury or other traumatic avent, ite Medical Exam are must be notified at an ance.		19a. Informant's Name/Relationship (Type		1	g Address (Street and				e, Zip Code)
ر ا	l and Health Im 27 har tr		Elaine Nufrio/moth		A COLUMN TWO IS NOT THE	1 Nina Lane sition (Name of	Prulti		D ZIBZO 20c. Location - City	or Town, State
Baltimore,	if ite		1 X Burial 2 ☐ Cremation 3 ☐ R		emetery, cren	natory or other place)	11/17		Hebron,	
Ë	it. Pa rtmer rtant njury		*4 □ Donation 5 □ Other (Specify) 21. Signature → Euror → Service ✓ ense	G	ardens					
Ba	Department Department		De Hol	11		Holloway F 501 Snow H	uneral H	ome Pr	ofessiona bury, MD	l Association 21804
	4, 15 %		23a, a /1. Enter the disease, or compli	cations that caused the death	h. Do not ent					Approximate Interval Between
	Physician		s ock, or heart failure. List only or improjete Cause (Final	Sizizur	· iZ	Diene	NZO			Onset and Death
	/Medical		diffase or condition resulting in death)		uence of):	DISOR	1010			
	Examiner		Conventially liet conditions	Due to (or as a consequence).	AUR	RRNA	L DRS	RAJ	12	
	70 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	wence of):					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CERRRR Due to (or as a conseq	OVAS	CHLAR	ACCI	5 BN 1		
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387	physicate s the l	edical								
9 x	eath certific attending p I for use as I	/Me	IF FEMALE: 23b. Wes decedent pregnant	3c. If yes, outcome of pregna		-			23d. Date of	delivery
Box	death a atter d for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown						
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ord	en s							1 🗆 \	res 2 2 No 3	Probably 4 Unknown
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=======================================	Th ete pag	S								Yes SENO
Vita	Physicien: This certificetral director, p	Be	25. Was case referred to medical examiner?	fospital:		Other	S. Place of Death			0
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my opinio	on, death occurre	d at the time,	date and place, and	due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and Title of certifier	and marinor states.		29c. License nu	umber		29d. Date signed (A	Nonth, Day, Year)
)	⊢ \$ ⊢ ŏ		1	1		200	53410	,	11-17	-67
•	For		30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type.	Print)	// 0		1 / /	
	La		6 Huiray WARLS	26266 AP	Power	OOP CT	STUSK	pay	uns.	21801
		ate	31. Date filed (Month, Day, Year)	and manner stated. completed cause of death (Iter 26 26 AP 32. Registrar's Signi	ature	book		,		
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DHMH 17 Rev 1/2001

Registrar

NOV 2 8 2007

		For	State of Maryland				Mental Hy	/giene		
		1 - State Registrar		Cer	tificate of l	Death		Reg. No.	107	38089
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Do Month	Day	Year	3. Time of Death
/Med		Emily A. Yurawed					Nov.	19,	2007	8:00 р м
Exami	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or		1		nty of Death	
		Manor Care - Che 5. Social Security Number 6. Sex	evy Chase 7. Age (In yrs. las	st birthdav)	Chevy If Under 1 Year	Chase If Under 24 Hrs.	8. Date of Bi	rth	ntgome	ry place (State or Foreign
Funeral Director			M 213xF 96	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Cou	achusetts
maybe gar		Usual Residence of Decedent					march	30,191		
rylan ihow I at	_	10a. State 10b. County		Town or Lo						10d. Inside City Limits
ne Ma 8a-f s	Director	Md. Montgome	ry Che	evy Ch						1⊈∏Yes 2∏No
vith the		10e. Street and Number	•		10f. Zip Code	0.1.5		10g. Citizen		intry?
eath vis 23g	eral	30805 Inverness D	2. Was Decedent Ever in U.S.	13 \		815	necify Ves or N		SA Race - Ameri	ican Indian.
yland 21213-UU36 ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atte event, the Medical Examinar must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Vas Decedent of H f Yes, specify Cuba		o Rican, etc.)	E	Black, White	
IMBRYIBING Z1Z13-UU30 d 2 should be filed within 72 hours af th and Mental Hygiene. t7 is marked other than "natural", or traumatic event, the Medical Exami	Š	3 ¼ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I∐Yes 2⊠No	Specify:		Spe	cify:	White
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	lent's Usual Occup- kind of work done of	ation	kina	16b. Kind o	Business/Ir	ndustry
Ithin lithin land	n d	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	ning .	11 C	Doot	Office
led w		12		CI	erk	18. Mother's Nan	an (Final Ministra		,	OTTICE
and lbe find ntal Hed of	Be	17. Father's Name (First, Middle, Last) John Suszynski.					anna Ga		iame)	
aryla should and Men s marke umatic	2	19a. Informant's Name/Relationship (Typ	ne Print)	19b Mailin	g Address (Street a				vn State 7	in Code)
and 2 s and 2 s ealth an n 27 is i		Marcia Bowen/Daugh	,		Inverne					·
Ore, INIARYIANG Z1Z13-UU30 ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of natory or other place	1	Date	20c. Location		
Pages Pages nent of l		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	-	eaven Cei	· i	29.07	 Silver	Spri	ng, Md.
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any Injury or other		21. Signature of Funeral Service License	-	22	. Name and Addres					0,
n alles	1 2	+ 1/0, + (1)	lay	22	22 Wiscon	nsin Ave	., NW.,	Washin		DC 20007
		23a Paril. Enter the disease, or complication shock, or heart failure. List only on	ations that caused the death.	Do not ente	er the mode of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Stroke						1	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):						
LAAIIIIIEI	Ļ	Sequentially list conditions, b	. Due to (or as a conseque	, non of):						
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o, nijul y that initiated events	Due to (or as a conseque	fice oi).						
bu, the executed sician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
Hecords, P.O. Box 68/60," The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	dical	A d								
tificate g physi as the l	ledi									
BOX 6 leath certific attending p	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal d		Ectopic pregnancy	,		23d.	Date of deliv	•
the dea	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown		Other (specify)				Month	Day Year
ries that the de signed by the a	Phy	Part II. Other significant conditions con	tributing to death but not result	ing in the ur	derlying cause give	an in Part I	23e Did	tohacco use c	ontribute to	the cause of death?
Hecords, he law requires the has been signed ge 2 should be d	b	Tark in out of digital out of the latest of	and any to document for the country		acitying cadoo give	on in the care is				bably 417 Unknown
COTA w require been sign should b	Completed				· •		24a. Wa	e an la	h Woro out	oney findings available
The law	교						auto	opsy formed?	prior to c death?	topsy findings available ompletion of cause of
	ပို	25. Was case referred to medical				26. Place of Dea	1 Yes		1 □ Yes	2 □ No
ysician: ysician: s certifica director,	O B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Oth	or:	lome 5 ☐ Res		Other (Spec	ifv)
ding Phys h. After this funeral dir		27. Manner of Death		28b. Time of Injury	28c. Injur Worl			how injury oc		
ath. or: Aff	atio	1 Natural 5 □ Pending investigation	(monin, bay roal)	mjar y		Yes 2 □ No				
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DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,						1				
e Hospital of 24 hours af e Funeral Dietely filled i	edical		sician: To the best of my knowl ner: On the basis of examinatio							
To the within 2 To the complete	Med	29b. Signature and title of certifier	and manner stated.	-	29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)
F≥Fö		james -			200	E/E//				
		30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Tvne		54566		Nov. 2	20, 20	U/
2		Sunitha Bhogavill	Li, M.D. 9801	Georg	gia Ave.	Suite 1-	17, Sil	ver Sp	cing.	Md. 20902
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire And	1/2)					
Regis	trar	NOV 2 8 2007	and the state of the	3						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Figure 1 Property Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Yalon Reuven October 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring Montgomer Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Se 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 102-30-5323 1**X**M 2□F Months 'Israel Director March Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show Md. Director Montgomery Silver Spring 1√PYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 11200 Blockwood Drive #115 20901 US 23a traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ☑ No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natura!" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Educator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Yalon Polly Gruen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Avi Yalon/ Son 608 Woodthrush Court Mt. Laurel, NJ 08054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 ☑ Removal from State 10/29/2007 Haifa, Israel B'Rosh Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any in Danzansky-Goldberg 1170 Rockville Pike Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a con sequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Tract Intection certificate be executed Due to (or as a consequence burial-t attending physician for use as the burial Resistant Staphalococcus aureus Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus Diabetes 1 Tes 2 No 3 Probably 4 Unknown End Stage Renal disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page performed? certificate 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending After 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

State

DHMH 17 Rev 1/2001

P.O.

Records,

or Vital

31. Date filed (Mont)

29b. Signature and title of certifier

13

2007

egistrar's Signature

lute MD

29c. License number

D0043539

iste is to Forest GlenRd. Silver Spring, MP 20910

29d. Date signed (Month, Day, Year)

October 26, 2007

State of Maryland / Department of Health and Mental Hygiene 38091 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11 Month 11/ 2007 **Physician** Jennifer Yates 12:40р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Cecil Elkton. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/12/1970 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ☐ M 2 👿 F 221-46-9727 36 California Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD Cecil Northeast 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Cedar Ln. 21901 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 is marked oth Be Jack D. Stevenson Lois Steele 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Lois Reynolds/ Mother 45 Collingsdale Ave. New Castle, DE 19720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □Cremation 3 □Removal from State Gracelawn Mem. Park 11/17/2007 New Castle, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Spicer-Mullikin Inc. 1000 N. DuPont Pkwy. New Castle, DE 19720 23a. Part1. Enter the disease, or complications the cause shock, or heart failure. List only one call in each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner incel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
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b the Funeral Director; A

completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Mulvey MD 111 W. High St. Elkton, MD 21921 32. Registrar's Signature 31. Date filed (Month Year) State 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State 1 - State Registrar	e of Maryland / Depa <i>Cer</i>	artment of H <i>tificate of L</i>		ental Hygi Re	ene _{9. N} 2 0 0 7	38092
F	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Emmer A. Yates		41. O't. T	Landa (Dark	Novemb		007 8:46P ^M
	Examin	er	4a. Facility Name (If not institution, give street and Southern Maryland		Clin	Location of Death		4c. County of Dea	Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign ountry)
	Director		238-50-1409 1□M 2X	F 74 Yrs.	Months Days	Hours Min.	(Month, Day, Teb. 28,	1933 I	NC
	put		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryla f shov ed at	ō	Md. PG		Hills				1 X Yes 2 No
	the N 28a-	Director	10e, Street and Number	Tempre	10f. Zip Code		10	g. Citizen of What C	ountry?
	h with	al Di	2711 Bellbrook Str	eet	20748		11	nited St	ates
	ems 2	Funeral	11 Marital Status 12. Was			ispanic Origin? (Spe In, Mexican, Puerto I		14. Race - Am Black, Wh	erican Indian,
2	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Y	es 2. XNo , Give	1 □ Yes 2 X No		,,		
2-0036	houra tural' al Ex	q pe	3 X Widowed 4 ☐ Divorced Year 15. Decedent's Education	or Dates:	dent's Usual Occupa	ation	1	Specify. Bla	
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717	filed within 7 I Hygiene. other than "r ent, the Med	Jom Som	2	ge (1-401 5+)	Nurse			Privat	:e
Maryland 2	0 00 _ >	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	, .	,	
<u>\</u>	nould be d Mental narked o natic eve	욘	James Odie	401 14 77		Emma D.			
<u>a</u>	ages 1 and 2 should b int of Health and Ment it if item 27 is marked or other traumatic e		19a. Informant's Name/Relationship (Type. Print) Trisha Yates Lewis	/daughter 13	304_Buc	hanan Di ington,	riye	City or Town, State,	Zip Code)
ย์	s 1 ar f Hea item 2		20a. Method of Disposition	20b. Place of Dispo	ort Wash sition (Name of	ington,	MQ 2 2 2	744 0c. Location - City o	r Town, State
Ē	Pages nent of I int: If Ite		1 ∰Burial 2 □ Cremation 3 □ Removal fi 4 □ Donation 5 □ Other (<i>Specify</i>)	Resurred			7/07	Clinton	, MD.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	1 22	. Name and Addres	ss of Facility Hoo	dges &	Edwards	F.H.
	<u>~</u> □ ⊑ ≅ ŏ		23a. Party. Enter the disease, or complications the						,Md.20746
		5 70	shody, or heart failure. List only one cause	on each line.	•			SI,	Approximate Interval Between Onset and Death
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	Examiner			to (or as a consequence of).					
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58/50,	icate be executed physician and s the burial-transit	al E	Duk	e to (or as a consequence of):					
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	e deat he atte	Physician/M	1 Tyes No 4P		Other (specify)	·		Month	Day Year
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cords,	w requires that the death certil been signed by the attending should be detached for use a	d by	HYPERTENCION.	te acam bar not rocam ig in an a				s 2 □ No 3 □ F	A
Ö	law req as been 2 shoul	lete					24a. Was an	24b. Were a	autopsy findings available
Ĭ	9 <u>E</u> 9	Completed					autopsy perform	prior to ed? death?	completion of cause of
VII A	ian: 'rtifica	Be C	25. Was case referred to medical examiner?			26. Place of Death			s 2 NO
_	Physician: Th this certificate ral director, pag	ToE	1 ☐ Yes 2 No Hospital:	I ☐ Inpatient 2 ☐ ER/Outpatien		4 LI Nursing Hon	ne 5 🗆 Resider	nce 6 □Other (Sp	ecify)
0 0	ding Physician: h. After this certific funeral director,	ion:	Natural 5 Pending	Date of Injury 28b. Time of Month, Day Year) 1 Injury	Work		28d. Describe how	v injury occurred	
UIVISION	death ctor: ,	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. P	lace of injury - At home, farm, stro		Yes 2 □ No	98f Location (Stre	eet and Number or F	Rural Route Number,
2	after after I Direct	Certification:	4 ☐ Homicide determined	uilding, etc. (Specify)	cot, factory, office		City or Town,		idiai Hodie Waniber,
	ospita hours unera ly fille	Sal		o the best of my knowledge, death					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	l edical	one) and	he basis of examination and/or in manner stated.					
	vit Cor	Σ	29b. Signature and title of certifier		29c. License			d. Date signed (Mor	
	,		20 Name and address of parson who completed	nause of dooth (Item 22a) (Tree-	D 50	689		11/17/	mtre.
	Ø		30. Name and address of person who completed 7503 JURRATE C	cause of death (Item 23a) (Type,	TUN O	KA 20	1) 7 m	2 5	M WE.
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signature	sales .	70	F 2 1		
	Registr	ar	NOV 2 8 2007	A STATE OF THE STA					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** EDWARD Novomber 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore State or Foreign Northwest Hospital <u>Randallstown</u> 8. Date of Birth Oct. 15, 1940 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 67 Maryland 216-36-2644 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f show notified at MD Baltimore 1 □Yes 2√ No Halethorpe Funeral Director 10f. Zip Code 10g. Citizen of What Country? 5720 First Avenue ms 23a or 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 之 No If Yes, Give Year or Dates: 14. Race - American Indian "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natui Injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) self employed Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Edward Amsel Helen McMenamin 19a. Informant's Name/Relationship (Type. Print) Leona Amsel - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5720 First Avenue, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 145 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or Oaklawn Cemetery 11-24-2007 4 □ Denation 5 □ Other (Specify) Dundalk, MD of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmoNA 24 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) detached a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DU(MONAN 2 No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy CENEBRO VAC QUIAN 1□ Yes 2 . No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Hipatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death, 2 Accident 24 hours after death Puneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year)

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State Registrar Oplando B 31. Date filed (Month; Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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VENTHENES!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygien 7 38094 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Louise Elaine Alexander 25-2007 12:15 A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Salishory 1 Hospice A+ The Loke () : comico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Days 577-22-3686 89 Yrs. 09/24/1918 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Wicomico Salisbury 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 232 Trooper's Way 21804 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give 1945-1965 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 **Military** Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Chase Caroline Yates 19a Informant's Name/Relationship (Type, Print)

Matrice Alexander / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 Trooper's Way, Salisbury, MD 21804 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 11/28/2007 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21. Signature of Funeral Service Licensee enda 21230 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DRSRASE ALZHEIMRA Due to (or as a consequence of) RENAL CHRANIC Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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"natural"

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturent injury or other traumatic event, It a Modical

Pages 1 and 2 should be filed within 72 hours after

permit.

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

Hospital

the

death.

Maryland 21215-0036

Baltimore.

Examiner count be notified at

Director

Completed by Funeral

Be

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Physician/Medical Examiner burial-transit use as the for should be detached Completed by page 2 Be After the f within 24 hours after deat To the Funeral Director: in by t lilled

Medical Certification: To

State Registrar

SHUCKEN 31. Date filed (Month, Day, Year)

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 48 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes P No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 THO patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ■ Natural 2 □ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D005 8416

Hospick P.O BOX 1733 SHVISBURY 450 21802

DHMH 17 Rev 1/2001

DENE!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

32. Registrar's Signature

ivision or	Vital Rec	Records, F	P.O. Box 68	68760,	*	Baltimore,		Maryland		21215-0036	9003						. 7	y.	
or Attending Physi fter death. Virector: After this on In by the funeral dire	Physician: The law this certificate has be ral director, page 2 s	v requires tha been signed should be det	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical Examiner ig physician and as the burial-transit	Physician	permit. Pages Department of I Important: If ite any injury or o	es 1 and 2 of Health a f item 27 is or other trau	2 should and Me is mark aumatic	be filed ntal Hyg ed othe event,	l within 72 jiene. r than "nat the Medica	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	23a or	he Mary 18a-f sh otified a	Director	Funeral	Exami	Physic /Medi	4	
rtification: To	Be Completed	by	Physician/Medical	cal Examiner				2	Be	Completed	d by Funeral		Director			ner			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	25. Was case referred to medical examiner?	Part II. Other significant condition	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DTNo 9 □ Unknown	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (ulsease or injury that initiated events resulting in death) Last	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	4 Donation 5 Other (Sp 21. Signature of Funeral Service L	Wilbert Leon Wilbert Bell 20a. Method of Disposition 1 ★Burial 2 ☐ Cremation	Albert Cooper 19a. Informant's Name/Relationshi Willbart Loop	17. Father's Name (First, Middle, L	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	10e. Street and Number 1732 E. Oliver		238–16–49.16 Usual Residence of Decedent 10a. State 10b. County	5. Social Security Number	4a. Facility Name (If not institution,	Rosa Bel	 State Registrar Decedent's Name (First, Middle, 	for State
28a. Date of Injunction attor 28e. Place of in		s contributing to death b		b. Due to (or as	nly one cause on each	ecify)		ip (Type. Print)	ast)	s Education grade completed) College (1-4or	If Yes, Give Year or Dates:	Street	IA			give street and number		Last)	Clate of IV
		out not resulting in the	2 Fetal death	a consequence of): a consequence of): a consequence of):	d the death. Do not a ine.	_	20b. Place of Dis		, -	5+) (Gi	? No		Balt	10c. City, Town or	ge (In yrs. last birthde)		С	
of 28c. Injury at Work? M 1 Yes 2		underlying cause given in Pa	3 □Ectopic pregnancy 5 □ Other (specify)		enter the mode of dying, such	s Mem. Pk. 22. Name and Address of Fa 1101 E. Nort	Syede St., sposition (Name of rematory or other place)	ailing Address (Street and Nur		cedent's Usual Occupation ve kind of work done during n b. DO NOT use retired) Crossing Guard	3. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 ☐ No Spec	10f. Zip Code 21213	imore		Months Days Hour	4b. City, Town, or Location		ertificate of Deat	partificate of Deci
□No 28f. Loc					as cardiac or respi	riat CH	Norristo	Pearl Moo	other's Name (First,	nost of working	ican, Puerto Rican,			8-	der 24 Hrs. 8. Dat		7	2. Dat	th
scribe how inj	a. Was an autopsy performed? Yes 2 k onl one)	1 🗆 Yes			ratory arrest,	F.H.					etc.)	10g. 0		22-191	e of Birth onth, Day, Yea 25–191	4	7 7	Reg. Note of Death	ii i iygi c i
jury occurred	prio deat	2 1 1 1 3 [23d. Date o Month			rbutus East re, Md.		y or Town, Sta		Kind of Busin	Black, \ Specify:	Citizen of Wha USA			9.	tc. County of I	4 2		200
Specify) r Rural Route Nu	e autopsy finding r to completion of h? Yes 2□ No	te to the cause of	f delivery Day	year	Approxim Interval B Onset and	4 55	401 y or Town, State	te, Zip Code)			American Indian, White, etc.	t Country?	**	N.	Birthplace (State			3. Time	1 38
ımber,	s available cause of	Unknown	Year	45	etween								es 2 No		_		30 PN	of Death	090

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

29b. Signature and title of certifier

Wendy Horsz 31. Date filed (Month, Day, Year) Charles St 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D31295

29d. Date signed (Month, Day, Year)

11/26/02

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38096 Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 15:21 Eric Brodfuhrer Nov 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Univ. of Maryland Medical Ctr. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 069-24-9039 76 OCT 6, Director 1931 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f show 1 ☐ Yes 2 No Director New Jersey Monmouth Little Silver 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 Lippincott Road 07739 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **5+** the Regional Manager Bell Telephone 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 Is marked of any injury or other traumatic eve once. ပ Erich Brodfuhrer Hermine Koch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte J. Brodfuhrer, wife Little Silver, NJ 6 Lippincott Road 07739 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 11/26/07 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Deorge 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 hrs RIPPLE MITTUS Immediate Cause (Final disease or condition resulting in death) Complications of C1 and C2 Fractures 18 **Physician** /Medical Due to (or as a consequence of) OVED BY MEDICAL EXAMINER **Examiner** Sequentially list conditions Que to for as a consequence of: if any, loading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the mount after cheeth Exami burial-trar Due to (or as a consequence of) CERTI Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page certificate 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 npatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred
Subject tripped and fell 28c. Injury at Work? Certification: 5 ☐ Pending investigation 11/19/07 1 Natural Injury 1 ☐ Yes 2 X No 2 Accident 3 Suicide 6:45 p^M within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sheffield Road 4 Homicide Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due of e cause's and manner is sale.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P22551 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Nathaniel J. Spencer 22 S. Greene Street, Baltimore, Md 21201 Dr. Nathaniel J.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2007

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32 Registrar's Signature

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nathan Andrev		ndus State of Mary	land / Departn	nent of He	ealth and Me				07 2200
	J	- For State Registrar	Certific	cate of De	eath	· · · · · · · · · · · · · · · · · · ·		. No. 4U	07 3809
Physicia edical Examir		1. Decedent's Name (First, Middle,Last) Jonathan Andrew Binda	S				Date of Death Month I November 2	Day Year	3. Time of Death 1320 hrs
Calcar Examin		4a. Facility Name (if not institution, give street and		4b. C	City, Town, or Location		vovember 2	4c. County of De	eath
		2020 Daniels Road		E	llicott City			Howard	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	N.		Jnder 24Hrs. 8 ours Min.		(MM/DD/YYYY) 9.	Birthplace (State or reign Mary Land
Director		214-54-6787 1XM 2	41	Yrs.			Dec 9,	1965	Country)
any	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location					10d. Inside City Limits
*	۲	Maryland Baltimore	Ca	atonsvi	lle				1 Yes 2 X No
daryland 28a-f show 1 at once,	Director	10e. Street and Number		10	f. Zip Code		100	. Citizen of What (Country?
th the Maryland 23a or 28a-f sho notified at once.		603 St. Johnsbury Road			21228			USA	
tems 2	uneral	1 Never Married 2 Married Armed	Decedent Ever in U.S. I Forces?		ecedent of Hispanic specify Cuban, Mexi			14. Race - Al White, et	merican Indian, Black, c.
ter dez ", or i	41	3 Widowed 4 Divorced If Yes, Give		1 Yes	s 2X No spec	cify:		Specify: W	nite
ours af atural	d b	15. Decedent's Education (Specify only highest of		a. Decedent's U	Isual Occupation (G	live kind of wor		16b. Kind of Busine	ess/Industry
Baltimore, MD 21215-0036 semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she njury or other traumatic event, the Medical Examiner must be notified at once	Completed		e (1-4 or 5+)		•	OT use relifed	,	Unatina	& Air
withingiene.	E O	12 17. Father's Name (First, Middle, Last)		Mech		ther's Name (F	irst. Middle. Ma	Heating	W ALL
215- e filed tal Hy ked ot nt, th	Bec	John K. Bindas				,	ny Vern		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	P	19a. Informant's Name/Relationship (Type, Print)			dress (Street and I				
MD ad 2 sh alth an m 27 i		Dorothy Bindas, Mothe				/		ville, M	aryland 21228
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27		20a. Method of Disposition 1 Burial 2 X Cremation 3 Remove	il from State crem	atory or other p	,				,
Baltime permit. Pag Department Important: injury or of		4 Donation 5 Other Specify:	Metro		tory Inc.		01/07		re, Maryland
Balt permit Departi Importi		21. Signature of Funeral Service Licensee Thomas Gregor		14Mac	Nabb Tuffe Frederic	ral Hor	ne, P.A Catons	ville M	aryland 21228
Physician		23a. Part I. Enter the disease, or complications that	at caused the death. Do	not enter the m	node of dying, such	as cardiac or re	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and
'Medical kaminer	- 0		Wound of Head						Death
Adimiler		or condition resulting in death) Due to (or a	is a consequence of):						
	ě		s a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a	is a consequence of):						
ecuted and and transit		events resulting in death) Last dd.							
s = 8	dical	UNPENDED X AMENDE	erME,g874, 12/	3/07 TT					
760, ficate be ex g physician the burial	cian/Medic	IF FEMALE: 23c. If ye	es, outcome of pregnant	су	leath 3 Ec	topic pregnanc	v	23d. Date of de	ivery Day Year
Box 68760, e death certificate be exemple attending physician and for use as the burial.	iciar	past 12 months?	egnant at time of death		(Specify)	stopio progridire		, month	20,
Bo ne deat the at	Physi		iknown			- D1	23a Did tol	anna una contribu	te to the cause of death?
, P.O. B ires that the d signed by the	by F	Part II. Other significant conditions contributing	g to death but not result	ting in the unde	enying cause given i	in Paπ I.			Probably 4 Unknown
ords, we requires is been signatured be	Completed						24a. Was a	n 24b. Wei	e autopsy findings available
COF	m p						autops	ned? dea	
tal Rec sian: The l certificate !	e Co	25. Was case referred to medical			26.Place of De	eath (Check on	1 Yes 2	No 1	Yes 2 No
of Vital Records, ng Physician: The law requir wher this certificate has been so meral director, page 2 should	8	examiner? 1 ✓ Yes 2 No	Inpatient 2 ER	Outpatient 3	Other	r		Residence 6	Other: Scene
	n:	27. Manner of Death 28a. D	onth Day Year)	b. Time of Injur		_ Is	8d. Describe h ubject shot	ow injury occurred self	_
ivision or Aftendiafter death. Director:	atio	2 Accident Investigation Nov	27, 2007 13	DUND: 806 hrs	1 Yes 2	2 V No			
Division fal or Aftendi rs after death. al Director: //	Certification:	determined /Spec	Place of Injury - At home offy) Parking Lot	, farm, street, fa	actory, office buildin		or Town, St		or Rural Route Number, City
Di Hospital 4 hours a Tuneral I		29a. Certifier 4 Continue Physician To the		death occurred	at the time, date an				
Division To the Hospital or Afteno within 24 hours after death To the Funeral Director:	edical	one) 2 Medical Examiner: On the ba	sis of examination and/o	or investigation,	in my opinion, deat	th occurred at t	he time, date a	and place, and due	to the cause(s)
F N F S	Me	29b. Signature and title of certifier	^		29c. License num				(Month, Day, Year)
		(I Certabe all			O.C.M.E.			November 28	3, 2007
3+1		30. Name and address of person who completed of			reet. Baltimore	. MD 2120	1		

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32. Registrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5.perFH.0873, 11/29/07 TT Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** braden arolun /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis ear If Under 24 Hrs. 8. Arunde Arundel Medical Center Year 8. Date of Birth (Month, Day, Oct 9, Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours Months Director 65 1942 Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov adical Examiner must be notified at 1 Yes 2 No Director Maryland Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20714 **USA** 4150 9th Street Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry r than " Elementary/Secondary (0-12) College (1-4or 5+) Antique Shop Owner Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ben Clem Louise Shephard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Cosby, Daughter P.O. Box 824 North Beach, Maryland 20714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any Injury or ot
once, 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/29/07 Baltimore, Maryland 21. Signature of Funeral Service Rensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death Mon (I) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breast cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undert, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident fter death Director in by the f 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier * 29c. License number 29d. Date signed (Month, Day, Year) WerlBeile, MD 11128107 D46052 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Stoud Belli, MD 2001 Medical Parkway

State Registrar 31. Date filed (Month, Day, Year)

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2007

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** -0 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Foresto lille Prince Kehad Greenges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 1 XM 2 □ F Director 579-62-0474 60 7-13-1947 Washington, DC permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ex miner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Prince Georges 1 ☐Yes 2 ☐ No MD Capitol Heights Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5239 Marlboro Pike 20743 Completed by Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Maryland 21215-0036 Specify Specify: **Black** 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Technician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larry Bradley Hattie Mae Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leavonia Bradley/Ex-Wife 5239 Marlboro Piķe, Capitol Heights, MD 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Washington National 12/1/2007 | Suitland, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th Street, NW, Washington, DC Pml. Enter the tile ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate C use (Final disease or condition arcinona With **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Jas page 2 autopsy certificate 1□ Yes Division or Vital 25. Was case referred the medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 atural or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of cenifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed eause of death (item 23a) (Type, Print) Ave, SE Washreyton, DC Souther 1328 h MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MARY ANN BABURA **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AA Drive Se CVA 117 Otis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/10/1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 6. Sex 5. Social Security Number Days Hours **Funeral** 1 ☐ M 2 💢 F Pennsylvania 202-26-7700 73 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Hygiene. 10b. County 28a-f show 1 ☐ Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Severn Maryland Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21144 117 Otis Drive Funeral 14. Race - Americen Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married White 1 □ Yes 2 🖾 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if then 27 is marked other than "ne any Injury or other traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kodrich Mary Thomas Elfred ပ 19a. Informant's Name/Relationship (Type. Print) (Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3407 Ridgewood Dr., Pittsburgh, PA. 15235 Mrs. Dolores Babura In-Law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 22. Name and Address of Facility Singleton Funeral & Cremation Service P.A.
1 Second Ave. S.W. Glen Pro-Scottdale, Pennsylvania Scottdale Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arterios cleratie Immediate Cause (Final SCASR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner that the death certificate be executed Exami burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical as attending p for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Year 1 ☐ Yes 2 No the a Division or Vital Records, P.O. 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Unknown , page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2□ No 1 Yes Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident ai or Attend s after death al Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Deput 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV Registrar

Registra

07-09107 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Teresa Mae Crandell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month November 25, 2007 0734 hrs **Medical Examiner** TERESA MAE CRANDELL 2 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7926 Bridge Avenue Rosedale **Baltimore County** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Day: Hours Director 218-84-3780 Country) 1 M 2 **X** F Yrs 11-4-1965 42 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD BALTIMORE ROSEDALE 1 Yes 2 X No 28a-f show items 23a or 28a-f shorust be notified at once. death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7926 BRIDGE AVE 21237 U.S.A. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. or iten 1 Never Married 2 X Married 2 X No Yes Widowed 4 Divorced f Yes, Give Yea Yes 2 X No specify: Specify: WHITE marked other than "natural", ic event, the Medical Examiner ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ should be filed within 72 DELIVERY FOOD 12 nt of Health and Mental Hygiene.

It: If item 27 is marked other th
other traumatic event, the Medi 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMUEL NAYLOR WANDA (HOOD) Be 19a. Informant's Name/Relationship (Type, Print) WANDA MAURER / MOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7926 BRIDGE AVE ROSEDALE, MD 21237 Pages 1 and 2 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department or Important: I METRO CREMATORY 11-29-07 CATONSVILLE, Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME AVE 21237 CHESACO ROSEDALE, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Methadone intoxication ⊂xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed and Physician/Medical X UNPENDED AMENDED #23a,27,28a-f, perMe,g874, 12/5/07 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? o ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, ficate has been s page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? certificate ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other; Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes ဥ No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pending Yes 2 X No the within 24 hours after death To the Funeral Director: FNd 11/25/2007 Fnd 7:25 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be 7926 Bridge Ave. Rosedale, MD determined found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Jack Titus MD. Deputy Chief Medical Examiner

State
31. Date filed (Mchiff, Day, Jean) 2007 32 Registrar's Signature

Registrar

30. Name and address of on who completed cause of death (Item 23a)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 25, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 2007 GEORGE COOK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner STUDER SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) Year) CROSS SPITAL MONTGOMERY Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 577-28-7326 Director NUN Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 ☐ No Director UB V MD MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be r ARCOLA 801 HUB Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NUN VUN \vee $\mu \nu$ UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NNN UNK ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HOLY CROSS HOSPITIAL SILVER FOREST GLEN RD SARING MD 20910 1200 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5Mother (Specify) in state 21. Signature of Funeral Survice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) a. A CURE RESPIRATORY FAILURE Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner PULHONARY FIBROID causationy list caracteris, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 ☑Unknown 2 No 3 Probably 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an has certificate 2 No Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

requires that the death certificate be executed Box 68760, P.0. Division or Vital Records, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Maryland 21215-0036

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHAN

D65*305*

29d. Date signed (Month, Day, Year)

and manner stated.

1500 FOREST GLEN RD NABILLIA SILVER SPRING. $\mathcal{D}\mathcal{C}$ 32. Registrar's Signature 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

(Check only one)

29b. Signature and title of certifier

NOV 2

9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ROBERT NIXON CAVIN 2007 /Medical 4a. Facility Name (If not institution, give street and number) , 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING MONTGOMER HOLY CROSS HOSPITAI If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Min. 8 Hours 1 M 2 □ F 5 NINN Director 578-64-135 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral" or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 □ No Director MD SILVER SPRINC MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant! If Item 27 is marked other than "natural", or items 23a or: ury or other traunatic event, the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be n SA 20910 9101 SECOND AVE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by 3 ☐ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNIX UNK NUN UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ NUN NUN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOSPITAL SILLER CROSS 1500 FOREST GLEN RD SPRING MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of H Important: If Ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature present a rivice Licensee Ronald S. Wade Dire State Anatomy Board 655 W. Baltimore Street Baltimore, Baltimore, MD 21201 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21201 Approximate Interval Between Onset and Death Immediate Ca se (Final disease or con Illion Physician ATRIA FIBRII disease or con life resulting in death) /Medical Due to (or as a consequence of) Examiner ARDIOMYOPA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed HEIRIRT FRILURE CONGESTIUE physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending p ass IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) by the a ☐Yes 2☐No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 2 No 3 Probably 4 Unknown 1 X Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has rector, page 2 autopsy 2□ No 1□ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 🔲 Inpatient 2 I ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation Injury 1 K Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: il Director: A within 24 hours af

To the Funeral D

completely filled in To the Hospital

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Day, Year)

16 homa) dayma

D58960

30. Name and address of person who completed cause of diam (Item 23a) (Type, Print)

ROCKVILLE PIKE ROCKVILLE MD KHAWAJA 11119 SAIMA 31. Date filed (Month, Day, Year)

State Registrar

NOV29 2007



29a. Certifier

Director

Be Completed by Funeral

2

Physician /Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once.

Physician

/Medical **Examiner**

	Please	e Type or P						•	ible.	
For State		State of	Maryland /		artment of I <i>rtificate of</i>	Health and I Death	, ,			00105
Registrar 1. Decedent's Nam	e (First, Middle, L	ast)		001	outo or	20411	2. Date of Deat		14/	3.4 ime of Death
	a Ailor (1					November	r 18, 2	2007	7:45 PM M
		ive street and numb	ber)		4b. City, Town,	or Location of Death			y of Death	-1
Stell	la Maris	Hospice			Timoni	um		Bal	timor	e
5. Social Security N		Sex 7 1 □ M 2 ☑ F	. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 1919	Cou	place (State or Foreign ntry)
Usual Residence o							Dan Ju	1717		yland
10a. State	10b. County		10c. City, To							10d. Inside City Limits
MD				Balt	imore					1X Yes 2 No
10e. Street and Nu					10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
3601 Cla	rks Lane					21215		US		
11. Marital Status		Armed Ford		13. V	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		ice - Ameri ack, White,	
1 □ Never Marr 3 📉 Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat			1 □ Yes 2 🗓 No			Speci	ify: bla	ack
(Sne	15. Decedent's cify only highest of	Education grade completed)	16	a. Deced	dent's Usual Occu kind of work done	pation during most of wor ed)	rking i	16b. Kind of E	Business/Ir	ndustry
Elementary/Seco		College (1-	4or 5+)		00 NOT use retire ceacher	ed)		educ	ation	1
17. Father's Name	(First, Middle, La	st)				18. Mother's Nan	ne (First, Middle, I			
Edwar	d Sumner	Ailor				Daisy	Adlena H	i11		
19a. Informant's N Edward		(Type. Print) : III/nepl	I			t and Number or Ru k Avenue				
4 M Donation	☐Cremation 3	☐Removal from S	ceme	of Disportery, cren	sition (Name of matory or other pla	ace)	Date	20c. Location	- City or T	own, State
21 Signature of F	uneral Service di	ensee D	irector		Name and Addr ate Anat	ess of Facility Lomy Boar		Baltin	nore :	Street
- 63		emplications that ca ly one cause on ea	used the death. De ch line.					est,		Approximate Interval Between Onset and Death
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that initiated event resulting in death)	5	c	r as a consequenc	e of):						
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Part II. Other sign	Ificant condition	s contributing to dea	ath but not resulting	in the ur	nderlying cause g	iven in Part I.		oacco use co es 2 □ No		the cause of death?
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examiner? 1 ☐ Yes 2 X] No	Hospital: 1 ☐ In	patient 2 ER/0	Outpatien	nt 3□ DOA Of	ther: 4 \(\sum \) Nursing \(\frac{1}{2}\)	Home 5 ☐ Reside	ence 6 K IO	ther (Spec	ify) HOSPICE
27. Manner of Dea 1 Natural	ith 5 ☐ Pending investigat		f Injury 28t o, Day Year)	Time of Injury	Wo		28d. Describe ho			
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		of injury - At home, g, etc. (Specify)	farm, str			28f. Location (Si City or Town	treet and Nun n, State)	nber or Rui	ral Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempletely filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physician/Medical Examine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NOV 29

State Registrar 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

43721

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma	aryland		artment of H rtificate of I		d Men	, ,	eg. No.?	07	38106
100	Physici	an	1. Decedent's Name (Fi	irst, Middle, Las	t)						Date of Deat Month		Year	3. Time of Death
. A.	/Medic		Marianne	e Teresa	Custer					No	Month vember	25, 2	007	5:17 p ^M
	Examir	er	4a. Facility Name (If not	institution, give	street and number)			4b. City, Town, or	Location of D	eath		4c. County		
			6711 Old I	Harford		n //n In .	at fairth dass	Balti If Under 1 Year	more If Under 24	⊟re o i	Date of Dieth		N/A	
10	Funeral			1[x 7. Ag □M 2⊋F	e (In yrs. las	Yrs.	Months Days			Date of Birth Month, Day,			place (State or Foreign ntry)
	Director	ij.	219-22-5445 Usual Residence of Dec			80				A1	ug. 25	, 1927	Mary	land
	yland yland at		10a. State 10t	b. County		10c. City,	Town or Lo	cation		-			1	10d. Inside City Limits
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	th the or 28;	Director	10e. Street and Number	r				10f. Zip Code			1	0g. Citizen of	What Cou	ntry?
	th wit 23a c 1st be	al [6711 Old H	Harford	Road			21234	+			USA		
	ems er m	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H	ispanic Origin an. Mexican. P	? (Specify	Yes or No-		ce - Americ	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 3 ☑ Widowed 4 □		1 ☐ Yes 2 ☐ I If Yes, Give 🛣 Year or Dates:	No		1 □ Yes 2√√2 No	Specify:		, ,		y: Whi	
Ö	2 hor	ted	15. (Specify o	Decedent's Edu only highest grad	ucation		16a. Dece	dent's Usual Occup	ation	working		16b. Kind of B	usiness/In	dustry
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pu	tai H d oth even	Be	17. Father's Name (Firs									Maiden Surnar	ne)	
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Maryland	d 2 sh th and 7 is n traun		19a. Informant's Name/					ng Address (Street						
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lor	ages int of t: if it			remation 3 🗆	Removal from State		_		8				-	
Baltimore,	permit. Pages 'Department of H Important: If Ite any Injury or ot		21. Signature of Funera			Met	ro Cr	ematory 2. Name and Addres	ss of Facility	$\frac{1/28}{11}$	/U/	Baltim	ore,	Maryland
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				isease, or comp	lications that caused one cause on each li	the death.								Approximate Interval Between
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4	/Medical		resulting in death)		Due to (or as	a conseque	nce of):						(1
	Examiner	_	Sequentially list condition	ons,	b									
	per lisit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
	execur al-trar	хап	that initiated events resulting in death) Last		c Due to (or as	a conseque	nce of):							
68760,	tificate be executed ig physician and as the burial-transit	edical E		·	d.									
	ifficat g phy as the	edi												
Box	attending for use	N.	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outcome 1 ☐Live birth			∃Ectopic pregnancy	,			23d. Da	ate of deliv	ery
	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the bunal-transit	Physician/M	in the past 12 mor 1 ☐ Yes 2 Ø No 9 ☐ Unknown		4□Pregnant a 9□Unknown			Other (specify)				M	onth	Day Year
P.0	hat th		Part II. Other significan	nt conditions of	ontributing to death h	ut not result	inα in the u	nderlying cause give	en in Part I		23e. Did tol	hacco use con	tribute to t	he cause of death?
Records,	signe d be	d by	Deriph	eral	VASCOU	2	7				1 □ Y			bably 4 □Unknown
CO	> 0 0	ete	7	Lie						_ -	24a. Was a	n 24h	Were aut	opsy findings available
Re	e la has	Completed	10100	J(00-							autops	med?	prior to co death?	mpletion of cause of
ta			25. Was case referred t	to medical					26. Place of	Death (C)	1□ Yes		1 🗆 Yes	2 □ No
or Vital	Physician: this certific	To Be	examiner? 1 ☐ Yes 2 ☐ No	-	Hospital: 1 ☐ Inpatie	ent 2 ☐ El	R/Outpatier	nt 3 DOA Oth	0.51			ence 6 □Otl	her (Speci	fv)
0	ਰੂ ≑ ਨੂ		27. Manner of Death	Pending	28a. Date of Inju	ry 2	28b. Time o Injury	f 28c. Injur Wor		1		ow injury occur	, ,	,
<u>S</u>	Attending r death. ector: After by the funer	atio	2 Accident	investigation			,,		Yes 2 □ No					
Division	or Att ter de Virect	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of inj building, et	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)						al Route Number,		
	urs af	S	00- 0-455 4 12	To wife in a Dis-	reielen. To the book	-fl					-l A - Al			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	ledical	29a. Certifier 1 (Check only 2 one)	Medical Exam	/sician: To the best iner: On the basis o and manner st	f examination	on and/or in	vestigation, in my o	ppinion, death	occurred a	at the time, d	ause(s) and m late and place,	anner as s , and due t	o the cause(s)
	To the within To the	Me	29b. Signature and title	offcertifier	10		4	29c. Licens	e number		2	9d. Date signe	ed (Month,	Day, Year)
			1/1/1	Lother	, They	. ~	10	029	5205			Novem	ber 2	6,2007
1	~		30. Name and address			leath (Item 2	23a) (Type,	Print) St. Bol	0.0	_				
4	f [*]		W. A. R.	ey 6 BI		M- Car's Signatu	harl	es St. Bal	to. Md	212	27			
	Sta Registi		31. Date filed (Month, E		2007 32. Hedistr	ais signatu LAGA a	B A	parke						

			1 - State Registrar Amend #30, per	State of Mary DVR,g873, 11/2				Mental H	ygiene Reg. No.	07	38107
	Physic /Medi		1. Decedent's Name (First, Middle, Last LUCY B. CHILES)				2. Date of D Month	Day _	5 200	3. Time of Death 7 1/13/pm
	Exami		4a. Facility Name (If not institution, give	tal of B	altin	re B	or Location of Deat	n Wa	4c. Co	ounty of Death	
	Funeral Director		5. Social Security Number 6. Se 213-34-4777 15 Usual Residence of Decedent	x 7. Age (In	yrs. last birtho	Months Day		(Month, E	infi Day, Year) —1920	Col	hplace (State or Foreign Juntry) RGINIA
les	death with the Maryland ms 23a or 28e-f show Irmust be notified at	tor	10a. State 10b. County MD • N/A		c. City, Town o						10d. Inside City Limits 1 X Yes 2 □ No
Chr	with the s or 28e be noti	Direc	10e. Street and Number			10f. Zip Code				of What Co	untry?
8	er death w Items 23a	Funeral Director	2007 FOREST PARI	12. Was Decedent Ever Armed Forces?	in U.S.	2120 13. Was Decedent of If Yes, specify Control of the control o		Specify Yes or Note Rican, etc.)	US.	A Race - Amer Black, White	
30	15-0036 n 72 hours after death with the Maryla "neturel", or Items 23a or 28e-f show	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	162 D	1 ☐ Yes 2 ☑ N				ecify: BL	
7		Completed	(Specify only highest grad	College (1-4or 5+)	(G	Give kind of work dor fe. DO NOT use reti URSES AID	ne during most of wo red)	rking		of Business/I MEDICA	·
ر لا	■ a a a a e	To Be C	17. Father's Name (First, Middle, Last) JOHN J. JONES				18. Mother's Nar		le, Maiden Sui	mame)	
hyan	Aaryla 2 should and Mer	-	19a. Informant's Name/Relationship (T		1	failing Address (Stre	et and Number or Ru	ural Route Num			
4	ore, M		JUNIOUS CHARLES 20a. Method of Disposition 12 Burial 2 Ocremation 3 1	20	0b. Place of D	09 LIBERT isposition (Name of crematory or other p		AVE . B		RE, MA	
africut	Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		* 4 □ Donation /5 □ Other (Specify,	K		MORIAL PA		-2007 DD FUNE			MARYLAND
Joseph	m 405 = 9		23a. Pain. Inter the disease, or comp	lications that caused the	death. Do not					E, MAR	Approximate
Ò	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final diseas) or condition resulting in death)	a. ATRIV	TC	AMELY	MMIA	,			Interval Between Onset and Death 7 WCER
	Examiner	10	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of)	Gtnu	from				2 weeks.
V	58760, Cricate be executed physician and sthe burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Appenc Due to (or as a cor			cen				6 mosths
	Records, P.O. Box 68 The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☐ Ho 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic pregnar 5 □ Other (specify)			23d	I. Date of deli	ivery Day Year
	rds, P	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in th	ne underlying cause (given in Part I.		tobacco use		the cause of death?
	Division of Vital Records, to attending Physician: The law requires taller death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed						24a. Wa aut per 1 ☐ Yes	opsy formed?	prior to c death?	itopsy findings available completion of cause of
	f Vital Registrian: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea	ath (Check only	one)		
	Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director,	tion: To	1 Yes 27 No 27. Manner of Death 17. Netural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpa 28b. Tim Inju	ie of 28c. In	Other: 4 Nursing Houry at Ork?		sidence 6 how injury od		afy)
	Division of	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm pecify)	, street, factory, offic	8	28f. Location City or To	(Street and N own, State)	umber or Ru	ıral Route Number,
	ne Hospit n 24 hours ne Funere	edical (29a. Certifier (Check only one) (Check only one) (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	/ knowledge, d mination and/o	leath occurred at the or investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and e, date and pla	d manner as ace, and due	stated. to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier				nse number	U		-	h, Day, Year)
***	2		30. Name and address of person who co	omit eted cause of death	(Item 23a) (Tv		06537	7	/Vove	noin	25,2007
	J		Aaron Rabinovich, MD	Sinai Hospital	Baltimor	re MD					
	Sta Registi	4 4	NOV 2 9 200	32. Registrar's S	Signature	gently					

	8903 stopher A	4 . Fo	ру	Please Type or Print in Black Indelible Ink. Ensure All Copic State of Maryland / Department of Health and Mental H		egible	Э.				
				- For State Certificate of Death		Reg. No.	2	00	7	38	10
84-	Phys			1. Decedent's Name (First, Middle,Last)	2. Date of De Month Novembe		Yea	ar		of Death	1
	lical Exa	amır		Christopher Ashley Foy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat			2007	of Death	L	11113	
4				Upper Chesapeake Medical Center Belair			Harford				
	Fune	ral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr		irth(MM	/DD/YYYY	9. Birt Foreig	thplace (State or	
	Direct	tor		141-74-5695 1XM 2F 27 Yrs. Months Days Hours Min	Nov. 2	23,	1979		₩ ^{ntr} VJe	rsey	
	>	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d In	ide City	Limits
	*	: .								Yes 2	
	nyland	tono	황	Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code		10g. Cit	tizen of Wh	nat Cou	ntry?		
0	he Ma	ified a	Dire	807 Delray Court 21050		U.	S.A.				
5	with t	oc not	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or N		14. Race		ican India	n, Black	ί,
$\frac{2}{2}$	death	unst	nue	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)			e, etc.			
	s after	niner.	à	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Tach.	Specify: Kind of Bu				
	hour.	Exan		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		160.	Kind of Bu	isiness/i	naustry		
	36 hin 72 e.	edical	Completed	12 Barber			Hairs	sty1	ing		
	215-0036 be filed within 7 ntal Hygiene.	the M	5	17. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First, Middle	, Maider	1 Surname	;)			
	Mer Mer	vent,	To Be	Charles Foy Helen M							
		atic e		19a. Informant's Name/Relationship (Type, Print) Helen Agins (Mother) 19b. Mailing Address (Street and Number or Borness (Mother) 807 Delray Ct., Fores					, Zip Co	de)	
	and 2 sho lealth and			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		Location		Town, S	tate	
	Baltimore, permit. Pages 1 ar Department of Hee	other		1 X Burial 2 Cremation 3 Removal from State crematory or other place) Fairview Cemetery 11-	-21-07	We	stfie	e1d	NI		
	Iltin	ry or	1	4 Donation 5 Other Specify 11- 21. Signature of Funeral Service Lensee 22, Name and Address of Facility Costa Memorial Ho				-14,			
	Den Den	injury	-	A Sommis (tellment 170 Central Ave.	, Hasbro	ouck	Hei:	hts	, NJ	076	04
	Physici			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory a	irrest, sh	lock, or he	art		oximate Ir een Onse	
7	/Medic		- 17	Immediate Cause (Final disease a. Methadone intoxication and clonazerom use complicated by							()
~				or condition resulting in death) Due to (or as a consequence of): bronchopneumonia							
			<u>ē</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					1		
		-	xamin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last use to (or as a consequence of):					+		_
	五 州	ansit		events resulting in death) Last Due to (or as a consequence or): d.							
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	760, cate be	he bur	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	a.penvr.,g		3d. Date o	, ,,			
The first in the f						Month Day Year					
	30X death	d for u	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown							
	P.O. I	etache	- 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o use cont				
	Lires th	d be d	ğ P		- 2		✓ No 3				
	ords w requ	shoul	ompleted	` <u></u>		opsy		prior to	utopsy fir completi		
	Reco	age 2	O F		per 1 ✓ Yes	formed?		death? 1 ✔ Y	'es	2	No
	ian:	sctor, p		25. Was case referred to medical examiner?							
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	n of	funer	ä	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending 1 11 17 (2007) P. 1 10 20 1 Yes 2 X No	28d. Describ	e now ii	ijury occur	reu			
	Division of Vital Records, tal or Attending Physician: The law requirers after death.	Atten		2 Accident Investigation Fnd 11/1/200/ Fnd 10:30 am 28e. Place of Injury - At home, farm, street, factory, office building, etc.	unk 28f. Location	(Street	and Num	ber or R	ural Rou	te Numbe	er, City
	Division the Hospital or Attend thin 24 hours after death the Funeral Director.	lled in	ertification:	Suicide 4 Homicide Government Governmen	807 Del	State)					
	Hospi 24 hou	tely fi	O	29a. Certifier 1 Certifying Physiciap To the best of my knowledge, death occurred at the time, date and place, as	nd due to the ca	ause(s) a	and manne	er as sta	ited.		
	the thin	mpk	dical	one) 2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred	d at the time, da	te and p	lace, and	due to ti	ne cause	(s)	

OCME State Registrar

Carle de

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 18, 2007

and manner stated.

Deputy Chief Medical Examiner

32 Registrar's Signatüre

30. Name and adviess of verson who contribeted cause of swetth (Item 23a)

29b. Signature and title of certifier

Mary G. Ripple MD.

31. Date filed (Month, Day Year) 2007

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yea **Physician** 11-18-2007 1:45 A Sarah Katherine Freburger /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Bel Air Health and Rehab. Center Bel Air 8. Date of Birth (Month, Day, Year) 08-18-1920 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 87 219-01-2269 Director Usual Residence of Decedent 10d. fnside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiens.
and if if item 27 is marked other than "nature!, or Items 23e or 28e-f ehow ury or other traumatic event, its Marifest Examines traumatic event, its Marifest Examines traumatic 1 ☐ Yes 2 No Harford Funeral Director Maryland Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 901 Barnette Lane Apt 319 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 4 Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Mulfinger Roger Barnes Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 54 Barrington Place Bel Air, MD 21014 Charles Freburger (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Depertment o Importent: If eny injury or once. 11-20-2007 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licensee man a. 9705 Belair Rd. Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure to thrive Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death signed by the e P.0. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Kidney Disease page 2 should 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Atrial Fibrillation 1 ☐ Yes 2 💢 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death [Check only one] Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of After 5 Pending investigation efter death. 1 Tes 2 No 2 Accident the the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours e To the Funerel D filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23a. Certifier Medicai completely 29c. License number 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 30. Name and address of person lanu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 Registrar

		1.	For State Registrar	State of Ma	ırylan	d / Depa	rtment o	f Health an	•	giene 0	07	38110	
N	iciar dica ninei	4a	Decedent's Name (First, Middle, JOSEPH Facility Name (If not institution, Facility Name (I 1746)	give street and number) H Wusir		FEDE	4b. City, Tow	n, or Location of C	imore	Day 16. Cour	Year 1,2007 nty of Death	3. Time of Death 3:40AM	
Funer Direct	_	2	Social Security Number L9-10-3224 suat Residence of Decedent	. Sex 7. Age 1뮻M 2□F	92	ast birthday) Yrs.	If Under 1 Your Months Da		Hrs. 8. Date of B Min. Nov. 4		9. Birthol Coun Mary1	lace (State or Foreign try) and	
the Marytan 28a-f show	10100	.	aryland Prince e. Street and Number	George's		t Wash		do.		10g. Citizen o		0d. Inside City Limits 1 ☐ Yes 2 🙀 No	
a or	Ē		13224 Park Lane				20744			USA	ii viilat oodii		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "naturel", or items 23a or 28a-1 show any njury or other traumatic event, the Madical Experiment or cultilists.	hy Emeral Directo	11	. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent B Amed Forces? 1				of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	o- 14. R	lace - Americ Black, White, o	etc.	
1215-0 vithin 72 ho ne. hen "natur a Mudical	Commissed		15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or 5	+)	(Give I life. D	ent's Usual Ockind of work do NOT use re	one during most of	working		Kind of Business/Industry		
Maryland 21215-0036 to 2 should be filed within 72 hours all lith and Mental Hygiene. 27 Is marked other then "nature!", or reaumatic event, It a Mudical Expiri	To Be Co	3 1	Father's Name (First, Middle, La John Thomas Fede			we	tuel		Name (First, Middle Agnes Mu				
and 2 shou balth and M n 27 is mar		15	a. Informant's Name/Relationshi Joseph John Fed		Son				r Rural Route Num				
Baltimore, Dermit. Pages 1 ar Department of Heal mportant: If Item; any njury or other		20	a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. P	lace of Dispos emetery, crem	sition (Name of atory or other	f place)	Date 1.1/30/07	20c. Location	n - City or To	wn, State	
Baltimo	once.	2	1. Signature of Funeral Service Li	censee		Fu 16	Name and Adneral 1 30 Edme	ddress of Facility (Home of (ondson Av	Sterling Catonsvil venue; Ca	Ashton le, Inc tonsvil	Schwab ie, MD	Witzke 21228	
IS, P.O. Box 68760, ————————————————————————————————————	al er	In di	3a. Part1. Enter the disease, or c shock, or heart failure. List or mediate Cause (Final sease or condition sulting in death) equentially list conditions, any, leading to immediate luse. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b	e. Da conseque Ch	eme of): i`\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11.	Melli rial f	tus		1	Approximate Interval Between Onset and Death V—Cars Y—Cars Y—Cars	
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of VITAL RECORDS, hysician: The law requires the contilicate has been signed director, page 2 should be continued.	Completed	-	Sick sinu	s syndro	me	-			aut	opsy formed?	prior to cor death?	psy findings available inpletion of cause of	
Vita ician: certifi ector,	ď	25	Was case referred to medical examiner?	Hospital:				- \ \ -	Death (Check only				
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Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Cartification.		3 Suicide 6 Could no determin	ed 286. Place of Inju	. (Specify	′)			City or T	own, State)		l Route Number,	
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6 5 ₹ 5 (3	4		Db. Signature and title of certifier	ny	/	00		ense number	91	Nover	nb-ev	28,2007	
7	State	3.	Name and address of person with the filed (Month, Day, Year)	3320 D-6 32. Régistra	N50	n Au	en ul	, Bult	n'more	Mary	land	28,2007	
Hegi	strar		NUV 4 3	COOL DESCRIPTION		4							

6+1

TERRY JODRIE, MID 31. Date filed (Month, Day, Year)

7503 SURRATTS ROAD, CLINTON, MARYLAND 20735 32. Registrar's Signature

NOV 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D40324

NOVEMBER 23, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 -18-2007 1.01 PM Mary Ann Faison 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Cliton 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 M 2 F Couintry) NC 73 2-19-1934 217-32-3719 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☐ No Washington, DC 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? IIS 1050 New Jersey Ave. Apt.105 20001 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Buildings Cleaning Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Smith Andrew Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) _N27874 Scotland Neck, 1910 Edward Folk Rd. Cornelia Dolberry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mary's Chapel 4 ☐ Donation 5 ☐ Other (Specify) 11-24-07 Scotland Neck, NC 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lendro Vasculas DISeas alheosa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 21/7 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a

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Department of Health al Important: If Item 27 Is any Injury or other trau

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physician and the burial-transit as attending for use the by 1 signed b peen certificate has page 2 Be Medical Certification: To this

that the death certificate be execu

P.O. Box 68760,

Division or Vital Records,

the Hospital or Attending Physician:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🏋 No 9 Unknown

Part II. Other significant	conditions	contributing to de	eath but not resulting in	the underlying cause given in Part
ahlan			0.0	the underlying cause given in Pari

		13.100 22.100	
25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spe	ecify)
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation		28c. Injury at Work? M 1 Yes 2 No	

Suicide determined 4 Homicide

29a. Certifier (Check only 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

3

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thin 24 hours after control of the Funeral Director: Afternal telephone in by the funeral telephone in the funeral telephone in the funeral telephone in the funeral telephone in the funeral telephone in the function of the

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State Registrar 31. Date filed (Month, Day, Year) NOV 2

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30. Name and address of pers

32. Registrar's Signature

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who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** George H. Fifer, Sr. Nov. 23 2007 130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie 7851 Americana Circle #104 Anne Arundel Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 ☑ M 2 ☐ F Director 89 705-10-2465 10, 1918 MD Sept. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Directo Anne Arundel Glen Burnie 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 7851 Americana Circle #104 USA 21060 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Railroad Conductor permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Fifer Marion Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ann Fifer/Wife 7851 Americana Circle #104; Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 29. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation Other (Specify) Maryland Veterans Cem. 2007 Brooklyn, MD 21. Signatur Se vice Licensee 22. Name and Address of Facility Singleton Funeral and Cremation Syc M01411 2nd Ave. SW, Glen Burnie, MD 21061 23a. Part1. Enterwhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Physician pear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-tran Division or Vital Records, P.O. Box 687600 Due to (or as a consequence of): Physician/Medical asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: No 1 Tyes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Harover St. Baltimore oung

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Registrar

31. Date filed (Month, Pay,

Year)

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32. Registrar's Signature

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No.? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** P M 2007 Nov. 26 Edwina J. Feld 6:18 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min 1 M 2 XF 219-28-1796 Yrs. June 3, 73 1934 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2X No Director Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 1 Baratra Ct. #302 21093 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pilarski Edward Macko Helen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Rick Spivey/Son-in-Law 2525 Girdwood Rd. Timonium, Maryland 21093 permit. Pages 1 al Department of Hea Important: if item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley Mem. Grd. 11/30/07 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licery 1050 York Road Towson, Maryland 21204 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List lications that caused e death. Immediate Cause (Final novolls Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and of for use as the burial-transit L^B resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tyes 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day Year) 5 Pending investigation 1 Natural 1 Yes 2 □ No 2 Accident neral Director: v filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001 29c. License number

29d. Date signed (Month, Day, Year)

Charle St. Ralts. Md 2020x

November 27, 2002

and manner stated.

6701

32 Registrar's Signature

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

BIMO

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:35.9 200 Frank W. Grant Jr /Medical 4a. Facility Name (If not institution, give street and number) Jown, or Location of Death 4c County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 28, 9. Birthplace (State or Foreign Country) Maryland ^{Year)} 1934 Jan 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Specify: white unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) 18. Mother's Name (First, Middle, Maiden Surname) Lucy Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7541 Westfield Road Baltimore, MD 21222 Date 20c. Location - City or Town, State State Anatomy Board 655 W. Baltimore Street 23a. Hart1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perforn 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2**X**No P 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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To the Funeral Di

completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 24, 2007 Month 7:19 **Physician** Garitte Fernanda November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 90 June 19,1917 166-10-9130 PA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Pittsburgh 1 No 2 No Allegheny PADirector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15210 USA 1947 Walton Avenue "natural", or Items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Dress Manufacturing Dress Maker 8 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be Maria Massart Zephirin Lebois ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2512 Allequippa Street, Pittsburgh, PA 15213 Scarlett Morgan/Power of Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) Jefferson Memorial Park 12/1/2007 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6 Pleasant Hills, PA injury 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Charles L. Stevens FUneral Home Inc. 1501 East Fort Avenue, Baltimore, MD any in R. Marshall orote 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vascular Disease Immediate Cause (Final Unknown 250 **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy 21**X**No 1□ Yes 2 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient Certification: To funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi

Medical

31. Date filed (Manth State Registrar

4 Homicide

29b. Signature and title

29a. Certifier

29c. License number 29d. Date signed (Month, Day, Year)

November, 24, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7,600 Carroll Avenue, Tolique Porth MD white James Drewry

and manner stated.

32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November Zenobia V. Gentry 0:40 M 000 T /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | Dec 23, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 T 298 20 0888 Ohio Director 86 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified 1 □Yes 2 📆 🔭 Director Maryland| Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3846 Eaves Lane 20716 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X Xo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Recruiting Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Reed Jones Viola M. Page 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carlene P. Brown (Daughter) 3846 Eaves Lane, Bowie., MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 30,2007 Lawn Cemetery Columbus, Ohio 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licen Alexandria Ferry Road, Clinton, MD 20735 23a. art1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** roling disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): burial-transit Physician/Medical Exam Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🔲 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation To the noopen...
within 24 hours after death.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-24-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per dr., g873, 11/29/107dhb) eath Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) David **Paul** Gayda Month **Physician** Dave ayda Ö /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MI toward 6 lumbre Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrş. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 12M 2 F Min 35-62-7900 Months Days Hours 0 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
snt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** MI owa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 N 00 RISIN 1/2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married Married ☐ Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify. Specify: What c 3 Widowed 4 Divorced Year or Dates: al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Gayda, Sr. Doris Smeltzer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6358 Rising Moon Road Columbia, MD 21045 Mrs. Cathy D. Gayda (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or ott
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Crematoin 11/28/2007 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licen HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Nu 1100764 Sykesville, MD 21784 (410)-795-1400 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Interction Physician /Medical Due to (or as a consequence of): Examiner oronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Obesity Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2.2.No 1□ Yes Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 2 No 1 Tyes after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pompletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 2007 050377 attending Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL PERLINE, 5755 CEDAR LANE COLUMBIA MO

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2240 M Nevember 24 F005 Brooke Jacqueline Allie Gaddis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns Hopkins Hospita 8. Date of Birth (Month, Day, Year)
Nov. 24, 2007 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2**X** F Yrs. Maryland 0 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director California St. Mary's Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20619 USA 23298 Misty Pond Lane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify White 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural any injury or other traumatic event, the Medical Exconce. Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erin Jennifer Golub James Raleigh Gaddis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James R. Gaddis/Father California, Maryland 20619 23298 Misty Pond Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/2/07 | Kinston, North Carolina Abbott Family Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lic 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 hours Extreme **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine /sician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 2 No 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the infector, page 2 s autopsy perform 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗆 Yes 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death.

To the Funeral Director; / completely filled in by the fi 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Nolfe Street Nelson 2-133 Bathmare, MD 21287 Johns Hopkins
31. Date filed (Month, Day, Year) ota 600 32 Registrar's Signature

State Registrar Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month Physician 9:00AM Nov. 24, Galkas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore OakCrest Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🕅 F March 15,1918 Maryland 89 Director 217-03-5053 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☑ No Director Parkville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 2 amy injury or other traumatic event, the Medical Examiner must be n once. 21234 USA 8810 Walther Blvd. #1623 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 □ Divorced ear or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 Defense Contracting Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anqelina Cicero Rosario Zaccari 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13953 Jarrettsville Pike, Phoenix, MD Lenore Zaccari/Sister in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery 20c. Location - City or Town, State Nov. Date 29. 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Juneral Service Inc. - LRB W. Clary 23a. Part1. Ent. If the & ease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) Physician neumonia /Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 Z No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 21 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work?

attending physician and Division or Vital Records, P.O. Box 68760 After this certificate has been signed by the a funeral director, page 2 should be detached or Attending Physician: The law requires that the after death filled in by within 24 hours a To the Funeral I

the Maryland

Baltimore, Maryland 21215-0036

28a-f show ns 23a or 28a-f shov must be notified at

> 1 ■ Natural 2 ■ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29d. Date signed (Month, Day, Year) 29c. License number 25 14 2007

21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FF00

and manner stated.

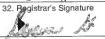
Partula

State Registrar

Londra

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 25 1-am FULL aurence NON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Howard Columbia MD 5. Social Security Number nouse If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2□ F Months Days Yrs <u>Maryland</u> 11/11/17 Director 90 215-10-1640 Usuel Residence of Deceden filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location rel', or items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Director Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 21044 Funeral 5400 Vantage Point Road 12. Was Decedent Ever in U,S. Armed Forces? 1 MLYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Š 3 ₩Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Texaco Mechanical Engineer 5+ other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o Nellie Nichols Bolden Judson Emmett Gary 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 6289 Clifton Rd. Clifton, Virginia 90603 Laurence H. Gary, Jr. / Son Important: If Item any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/1/07 Baltimore, Maryland Loudon Park Cemetery 22. Name and Address of Fecility Loudon Park Funeral Home 21. Signature of Funeral Service LicerSpe 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): Examiner EMEN physician end s the buriel-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 edical Due to (or as e consequence of): Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Tunknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Touse 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospitel: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpetient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 1 Naturel 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident efter death Director: / d in by the f 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifie NOV, 25 ENNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

300 ARMORY 31. Date filed (Month, Day, Year)

2 9 2007

AMEND TTTM/7.8 per TL 087/1.12/6/07 Watch and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** 2P M SAMUEL E. GREEN 26,2007 NOV. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE 1908 LAFAYETTE AVE 8. Date of Birth If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1, M 2 □ F 24 5768 217 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 1 X Yes 2 □ No ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f st injury or other traumatic event, the Medical Examiner must be notified Director BALTIMORE N/A MD. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21213 LAFAYETTE AVE. usa 1908 E. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or how any injury or other trans. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify BLACK 3altimore, Maryland 21215-0036 Specify <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) STEEL INDUSRRY STEELWORKER 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERLEASE MCCONNELL HENRY GREEN SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD. 21218 32nd ST. 1925 e. EDGAR GREEN SR. (brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, smock, or heart failure. List only one cause on each line. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonis **Physician** Assiration Unknow /Medical Due to (or as a consequence of): Examiner Unkyon Conces aryngeal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ProSTATE ances Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 24a. Was an autopsy performed? (es 2 No 1□ Yes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 20 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Tes Certification: To 27. Manny of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier XX59056 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Balt 6821 Reistorstan RZ Saluja 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 NOV29

2007

State of Maryland / Department of Health and Mental Hygien 7 0 7 38123 Amend #9, perFH, g873, 11/29/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Des Year **Physician** 1212 DW November 26 7007 /Medical 4e Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner AUGSBURG LUTHERAN HOME **GWYNN** OAK BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**√** M 2□ F Yrs. 79 Director 228-26-1327 6/08/1928 UNK Usual Residence of Decedent with the Menylend 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location show r than "natural", or items 23s or 28e-f shor the Medical Examiner must be notified at 1 ☐ Yes 2\ No MD **Funeral Director** BALTIMORE GWYNN OAK 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3800 VILLA NOVA ROAD 21207 USA Pages i and 2 should be filed within 72 hours efter death nent of Heaith and Mental Hyglene.
int: If item 27 is marked other than "naturei", or items 23 12. Was Decedent Ever in U,S.
Armed Forces?
US
10 Yes 2 □ No
If Yes, Give
AR 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🎖 ☐ No Specify: ARMY Specify: BLACK Completed by 3 ₩ Widowed 4 Divorced Year or Dates WW II 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) PROPERTY PROTECTION SECURITY GUARD other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGINA MAYBIN / NIECE 3800 VILLA NOVA ROAD, BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VETERANS CEMETERY 12/03/07 OWINGS MILLS, MD

GARRISON FOREST 20a. Method of Disposition Important: if it any injury or o N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Separtment** 21. Signature of Funeral Service Licenses HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD , or complications that cau led the de List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such es cardiac or respiratory arrest, Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) dementin 193cm/aears **Examiner** Due to (or as a consequence of) Physician/Medical Examine The lew requiras that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). of Vital Records, P.O. Box 68760. physician s the buriel Due to (or as a consequence of) attanding ph signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? cartificata has b diractor, page 2 s 21**5**No 1 ☐ Yes 2 ☐ No 1 Vas diractor, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

AI Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ۵ 1 Yes 2€No this funeral 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1. Natural after death.

Director: Aft
i Director Aft 1 Tes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 0 To the Hospital within 24 hours a To the Funeral Completely filled Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caute of deeth (Item 23e) (Type, Print) Main Reidenstown MD 21136 MD 25 24 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 2

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and

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	-	For State	State	oi waryia		rtificate of	Health and N Death			707	20121
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/Medica Examine		4a. Facility Name (If not institution	, give street and n			4b. City, Town,	or Location of Death		4c. Cou	inty of Death	
LAMITIME	"	Baltimore VA	Medical	Center		Balti	more				
Funeral		5. Social Security Number	6. Sex 1 ★ M 2 ☐ F	7. Age (In yr.	s. last birthday	Months Days	r If Under 24 Hrs.	8. Date of Birt (Month, Day	r, Year)	Cou	place (State or Foreign ntry)
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and w	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town or L	ocation					10d. Inside City Limits
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r dea	Funeral	11. Marital Status	Armed F	cedent Ever in Forces?	U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14.	Race - Ameri Black, White,	
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12 sh h and 7 is m traum		19a. Informant's Name/Relations									
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 death and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 4	Betty B. Hughes 20a. Method of Disposition	3/Motner	20b	Place of Disp	osition (Name of	er Road, N	Date Date		C 294 on - City or T	
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To wit		29b. Signature and title of certifie	/ WY				176435Z	18194	Noil	21	2007
ń		30. Name and address of person	who completed ca	use of death (If	tem 23a) (Type	e, Print)			1 - 0		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 12:20 P M 17, November 2007 LeRoy Corbett Hand, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 X M 2 □ F Yrs 62 Aug. 8, 1945 Virginia Director 245-74-2340 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20817 U.S.A. 8606 Bradley Blvd. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Engineering/Sales Elementary/Secondary (0-12) College (1-4or 5+) Advanced Technology CEO Tiei Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LeRoy Corbett Hand, Jr. Iris Langston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8606 Bradley Blvd., Bethesda, MD 20817 Linda McClure Hand (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Gatesville Cemetery 11-23-07 Gatesville, NC 4 Donatton 5 Dother (Specify) / 21. Sign Ture of Funeral Service Licensee 22. Name and Address of Facility
Miller Funeral Home P.O. Box 23, Gatesville, NC 27938 11 vum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arteriosciento coccionasculos dise Physician immo dia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to firm solic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 TYPS 2 No Ö 9 Unknown <u>م</u> signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28a Date of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/17/2007. Gucherman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgetone Rd mozo814. ER 8600 evgenly Gincherman, MA Benesda 32 Registrar's Signature 31. Date filed (Month, Day, Year) State THE PARTY OF THE P Registrar

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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:00 A M NOVEMBER 27, LOUT Dean Hanks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Arnold Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUN 19 1926 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months 81 Director 451-34-7930 Kansas Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or Items 23a or the Medical Exercitive must be: 400 Master Derby Court 21409 **USA** Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Heelih and Mentel Hygiene. antif Item 27 is marked other than "natural", or ite marked other than "natural", or ite myror other traumatic avent, the Madical Exeminary or other traumatic avent, the Madical Exeminary 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Leslie Hanks Mable Roxie Chisholm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Hanks - sister-in-law 400 Master Derby Court, Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: any Injury o 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/27/2007 Baltimore, MD 21. Signature of Funeral Service Ligensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ADVANCED DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes certificete 1□ Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident efter death Director; , I in by the f 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellil Funeral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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DHMH 17 Rev 1/2001

Registrar

market

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Rea. No. 2007 State Registrar Amend #1, perMD, g873, 11/29/07 TT 1. Decedent's Name (First, Middle, Last) Leroy Joseph Holt, Sr. 2. Date of Death Month Dav Year **Physician** 1210 AM NOVEMBER JOS EPH 2007 /Medical 4a. Facility Name (not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS SUHOS OSPITAL HALTIMOKE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. b. Date of Birth (Month, Day, Year) Oct 12, 1934 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 73 220-30-4483 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 XNo Directo Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21221 336 Poplar Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland Air Elementary/Secondary (0-12) College (1-4or 5+) Traffic Management National Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Hall Lee Rov Holt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Holt, Wife 336 Poplar Road Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/26/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit TUMOR SLAIN Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician the attending pl IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown WISCASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably ACTEM Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury thours after death.

uneral Director; Afely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RE5-000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMULE HOSPITAL GOON. WAFE THE JOHNS HOPKINS Woodsorth GRAEME 32. Degistrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** HOLSTE 1:15 PM HOVEMBER 28 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BATWEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 6, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**7** F Director 218-18-7165 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer must be notified at N/A Baltimore Maryland 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Brandan Avenue 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 f Yes, Give 1 ☐ Never Married 2 ☐ Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3X Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Office Work 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Barrera Mamie Vaeth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard C. Holste Jr. 394 Pacific Street, Brooklyn, New York son 11217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cem. Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222 21. Signature of Juneral Service Licensee Part. Enter the disease, or complic from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Pari Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician 20 Hours /Medical Due to (or as a consequence of) 5 DAYS **Examiner** PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed use as the burial-transi Pg 9 Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 🗆 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature RES-000 NOVEMBER 28, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21224 EMMANUEL GOROSPE, MD 4940 EASTERN AVE.

State Registrar 32. Régistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** M. Hetrick Havard November 19 3:50 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Battimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 70 Director 578-48-7375 Feb 14, 1937 Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits other then "netural", or Iteme 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No MDBaltimore Dunda1k Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 North Point Road 21222 USA filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk mechanic automotive nt of Health and Mental Hygie I: if Item 27 ie marked other i or other treumatic event, the permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Importent: if item 27 is marked othway in lury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Hetrick Elizabeth Fort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 North Point Road Dundalk, MD 21222 Katherine Hetrick/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4□Donation 5♥Other(3pec(γ) in state 21. Signature of Funeral Service Licensee Director State Anatomy Board 655 W. Baltimore Street an Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ck, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure Ihour /Medical Due to (or as a consequence of): Examiner 3 week Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the buriat-transit the attending physiclen and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year deteched for in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate hes been signed by a page 2 should be detect Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No 1 ☑ Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerai [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 19, 2007 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4940 Easton Avenue Buttimere, MD 21224 Jennifer Chena 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vivian E. Hynes November 28, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paradise Assisted Living Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 😾 F Months Sept.13,1924 Director 215-22-4073 83 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sl injury or other traumatic event, the Medical Examiner must be notifled 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1254 Circle Drive 21227 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 ☐ Yes 2 [x]
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2€ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. 2 Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within tof Health and Mental Hygiene. If Item 27 is marked Elementary/Secondary (0-12) College (1-4or 5+) 12 Steno Clerk Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. Riggs Bessie E. Kane ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1254 Circle Drive; Baltimore, MD 21227 Jacqueline Hynes Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/29/2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Think Immediate Cause (Final **Physician** disease or condition resulting in death) 10 cardi /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and / burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ₩ No 24a. Was an performed certificate 200 No Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Sisted Living 1 ☐ Yes 2 KNo 1 | Inpatient 2 ER/Outpatient 3 DOA ၉ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending F after death. Certification: 1 Natural 5 Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) License number

Registrar
DHMH 17 Rev 1/2001

State

of death (Item 23a) (Type, Print 0. 405

32 Registrar's Signature

10:10 A^M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Unknowy

anknown

Year

Day

2 🔀 No

1 ☐ Yes 2 → No

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Shirley Matilda Harrer Nov 24. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours 73 Director June 12, 1934 Washington DC Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County ir than "natural", or Items 23a or 28a-f st the Medical Examiner must be notified Director Maryland Prince George's Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6701 Coolridge Ave 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give X 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☐ Widowed 4 ▼ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Brooker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Herbert Cole Elsie Schwettman ၉ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Cole (Brother) P.O. Box 797, Temple Hills, MD 20757 permit. Pages 1 a Department of Hea Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Nov 30, 2007 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Societe Licensee 0 Alexandria Ferry Road, Clinton, MD 20735 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Corner with Mets to breast /Medical Due to (or as a consequence of): **Examiner** acciden Cerebovalalar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence of Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 1□ Yes 2 **X**No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 □ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 ☐ Accident Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide within 24 hours a 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZI M.D 1) 43446 11.24.07 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver spring MD 20209 11.0 FARAHIFAR 9801 Georgia Avesuit 3-41 ROINTAN 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 26, 2007 1740 **Physician** Constance V. Hairston /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M #□F 223-32**-**9890 22, 1921 Chicago, Ill Aug. Director 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more once. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Washington DC. 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 867 21st Street, N.E. 20002 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify. by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elinora Hawkins Robert Walker ပ 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1440 Oak Street, N.W. 19a. Informant's Name/Relationship (Type. Print) Washington DC 20010

20b. Place of Disposition (Name of cemetery, crematory or other place) Doris Murray/Grandaughter 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Howard University Med Sch 11/28/07 Washington, DC 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Lie 3821 14th Street, N.W., Washington, DC ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. shock, or heart fature. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has page 1□ Yes 2 🔀 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 ☐ No 1 Nnpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours af

To the Funeral D

completely filled i Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSENER PARKWAY GREENBELT MARYLAND 2070 -5A 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 29 Registrar

Sanford Lee Hoskey State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 28, 2007 0022 hrs Medical Examiner Sanford Lee Hoskey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1309 Iron Forge Road Oxon Hill 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Country) FL Hours Months Director 263-93-0578 X M 2 28 7-15-1979 Usual Residence of Decedent ì 10a. State 10c. City, Town or Location 10d. Inside City Limits Prince George Forrestville 28a-f show ME 1X Yes 2 No hours after death with the Maryland rector 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20747 1309 Iron Fordge Road USA items 23a Funeral 11 Marital Status 1 Never Married 2 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married Yes African-American Yes, Give Year Yes 2 X No specify: Divorce þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) ftimore, MD 21215-0036
it. Pages I and 2 should be filed within 72 hos
rment of Health and Mental Hygiene.
retant: If item 27 is marked other than "na Elementary/Secondary (0-12) College (1-4 or 5+) 11th Production Worker Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sanford Lee Hoskey Sr Delphine Denise Daniels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delphine Denise Daniels/ Mother 527 West Fla. Avenue#1, Haines City, Fl. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State fimore, other crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 12-8-07 rtment ortant: New Oakland Haines City, FL 4 Donation 5 Other Specify: 0. 22. Name and Address of Facility Wylle Funeral Homes P.A. 21. Signature of Funeral-Service Licensee 638 N. Gilmor Street, Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown this certificate has been signed by the a director, page 2 should be detached fi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medica 26.Place of Death (Check only one) Be Hospital: Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes No After 28a. Date of Injury (Month, Day Year) Nov 27, 2007 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural 2345 hrs Director: Yes 2 V No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 1309 Iron Forge Road, Oxon Hill, MD determined (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State of Ma	aryland /				d Mental Hy	/giene			0.1
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	rtificate of	Deain	2. Date of D	Reg. No.2	007	3. Time of [Death
4	Physicia		Mary E. Hamilto						Month Nov.	Day 24	Year 2007	1:30	A M
100	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of De	eath	4c. C	County of Death		
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44	Funeral Director		218-16-1813	6. Sex 7. Ag 1 ☐ M 2 🖾 F	je (In yrs. last b 99	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Hrs. 8. Date of B (Month, D May 25	ay, Year)	Cou	place (State or ntry)	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City	y Limits
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	r 28a	Funeral Director	10e. Street and Number	ditaci	Olen 1	JULII	10f. Zip Code			10g. Citize	en of What Cou	ntry?	
	th wit	alD	7575 E. Howard	Rd.			21060			USA			
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0- 14	 Race - Ameri Black, White 		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	No		1□Yes 🚈 No	Specify:		5	Specify: W	hite	
21215-0036	2 hou	ted	15. Decedent's	s Education	16	a. Dece	dent's Usual Occup	pation		16b. Kind	d of Business/Ir	ndustry	
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	led wi lygien ner th nt, the	Completed by	12		Ho	omem	aker	10 Mathada	Name (First, Middl	Own			
Maryland	t be find He otler	Be	17. Father's Name (First, Middle, L	ast)					Fishpaw	e, maiden s	ourname)		
IZ,	should nd Me mark matic	ဥ	Wilbert Parks 19a. Informant's Name/Relationsh	ip (Type. Print) Cross	a 19	9b. Mailir	ng Address (Street		r Rural Route Num	ber, City or	Town, State, Zi	p Code)	
	alth an 27 is or trau		Arlington Leroy		1	440	Bradford	Ln.; Pr	rince Fre	deric	k, MD 2	0678	
ore,	of Head		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		20b. Place	of Dispo	sition (Name of matory or other pla	201	Date vember 28	20c. Loc	ation - City or T		
Ĕ	Pages ment of I ant: If Its ury or o		4 □ Donation 5 □ other (Sp	ecify)	Saters		ptist Ch.	Cem	2007	Luth	erville		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature, if Junera Sprice L	icensee	M0141				Singleton len Burni			Cremat	cion
l.			23a. Par 1. Emer the disease, or of shock, or heart failure. List of	complications that cause only one cause on each li	d the death. Do	o not ent	er the mode of dyi	ng, such as car	diac or respiratory	arrest,		Approximate Interval Bety Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Caec	liac	An	yllmia	-				Oriset and D	reau
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):	Itale						
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	certific ding p	/Mec	IF FEMALE:	23c. If yes, outcome	on pregnancy						Od. Data of dali		
Вох	death certifi e attending id for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal dea		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23	3d. Date of deli- Month		/ear
Ö	0 00	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown			- (, 2, -						
Records, P	requires that the de een signed by the a nould be detached f	by	Part II. Other significant conditio	ns contributing to death t	out not resulting	in the u	nderlying cause giv	ven in Part I.			se contribute to] No 3 □ Pro		eath? Inknown
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Re	9 <u>L</u> 9	omp							— aut per 1□ Yes	opsy formed? 2 No	prior to c death? 1 ☐ Yes	ompletion of ca 2 □ No	use of
ita		Be C	25. Was case referred to medical					26. Place of	Death (Check only		1 163		
۲ \		70 E	examiner? 1 ☐ Yes 2☐ No	Hospital: 1 Inpati		_ <u> </u>		4 Deforsi	ng Home 5□Re	sidence 6	□Other (Spec	rify)	
n c			27. Manner of Death Natural 5 ☐ Pending			. Time o	Wo		28d. Describe	how injury	occurred		
Division or Vital	or Attending after death. Director: Aftel in by the fune	icati	2 ☐ Accident investign 3 ☐ Suicide 6 ☐ Could n	ot be 380 Blace of in	iury - At home.	farm, st	M 1 Treet, factory, office	Yes 2 □ No		(Street and	l Number or Ru	ral Route Num	ber.
Σ	after after I Direct	Certification:	4 ☐ Homicide determin	building, e	tc. (Specify)	,				own, State)			,
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								510	48	11	21-0	51	
	4		30. Name and ad ress	who completed cause of	death (Item 23a	Type,	Print)	AIP K	hnap	nlis	MA -	DILICI	
	Sta	ite.	31. Date filed Month, Day, Year	32. Regist	rar's Signature	MIC	9191	110.1	WILLIAM	OID	111).0	2176/1	
Po	Registi		31. Date filed Month, Day, Year NOV 2 9 2	007 Alexander	Ash as	STANA	Charles						

Registrar

DHMH 17 Rev 1/2001

		_ For	State of Maryland			Mental Hygier	ie		
		1 - State Registrar		Certificate of	of Death	Reg. N	Reg. No 2007 38		
Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	ay Year	3. Time of Death	
/Medi		Margaret		edrick			2007	1:55 A ™	
Examir	ner	4a. Facility Name (If not institution, give st			n, or Location of Death linton		lc. County of Death Prince Ge		
Funeral		Bradford Oaks Nurs 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday) If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign	
Director		232 24 4766	M 2MT 85	Yrs. Months Da	ys Hours Min.	(Month, Day, Yea April 14,	1922 Wes	st Virginia	
w w		Usual Residence of Decedent 10a. State 10b. County	10c. Cify,	Town or Location				10d. Inside City Limits	
Maryla f sho ied at	jo.	Maryland Prince Ge	orge's	Temple	Hills			1 □Yes 2 No	
r 28a-	Director	10e. Street and Number	8 9	10f. Zip Coo		10g. (Citizen of What Cou	intry?	
th with 23a o ist be	aD	3709 Gull Road	l	2	.0748	τ	nited Sta	ates	
r deal	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	5. 13. Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White		
OUSO nours afte urai", or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Λ Year or Dates:	1 ☐ Yes 2☐	No Specify:		Specify: Wh:	ite	
2 hours	ed	15. Decedent's Educ	ation	16a Decedent's Usual Oc	cunation	16b.	Kind of Business/li	ndustry	
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ylarid build be file Mental Hy arked oth attic event	Be	17. Father's Name (First, Middle, Last) Fleming S. If	Jamrick			ne <i>(First, Middle, Maid</i> ena Gregory			
rylic hould id Mei mark matic	2	19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Str				in Code)	
Manud 2 sl		Beverly Pazak (D	,	9802 Church					
ss 1 and stem stem stem of the stem stem of the stem stem stem stem stem stem stem ste		20a. Method of Disposition	20b. Pl	I ace of Disposition (Name o emetery, crematory or other	f place) Dec 3.	^{Data} 007 ^{20c.}	Location - City or 1	Town, State	
altimor		1√ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	nt Mountain (I .	ster Spr	ing, WV	
DESILITION PORTORY INTERVIPED A LATE 103-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Funeral Service License				e Funeral l			
0 00 E 9 0		23a. Pan. Enter the disease, or complic	1701391			Road, Cli	nton, MD		
		shock, or heart failure. List only on	e cause on each line.					Approximate Interval Between Onset and Death	
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g phy as the	ledic	0.							
ath cer attendin or use	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome pf pregnar 1□Live birth 2□Fetal		ancv		23d. Date of deli		
the at	sici	in the past 12 months? 1 □ Yes 2√√No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown				Month	Day Year	
that the ed by detacl		Part II. Other significant conditions con	tributing to death but not resu	Iting in the underlying cause	e given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?	
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he law requires has been sign ge 2 should be	Completed					24a. Was an	24b. Were au	topsy findings available	
_ w m	omp					autopsy performed 1 Yes 2 □	? death?	completion of cause of 2 ☐ No	
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Or VITa Physician: r this certific ral director,	은	1 Yes 25 No H		ER/Outpatient 3 DOA		lome 5 ☐ Residence		cify)	
JII C	lon:	27. Manner of Death 17 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how it	njury occurred		
Invision or Attending after death. Director: Afte	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At ho	me, farm, street, factory, of		28f. Location (Street	and Number or Ru	ıral Route Number,	
ai or / s after il Dire	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, S.	tate)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical (ician: To the best of my knowner: On the basis of examinat						
the P	Medi	one) 29b. Signature and title of certifier	and manner stated.		cense number		Date signed (Monti		
P i i i		250. Signature and time of certifier			94536J		1 - 27 -		
; A	1 8	30. Name and address of person who co	mpleted cause of death (Item		7 - 70-	,	1 01		
8	2	Michael Sidaro		1 Livingstor	Road #101	Ft. Washi	ngton MD	20744	
	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ture					
Regist	-71	NOV 2 9 200	1 July States As	4 Agreedy					
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Phys

	1	For State Registrar	state of Mary		rtificate of l			Reg. No.2	007	38136	
ician		1. Decedent's Name (First, Middle, Last)	1.				Date of Dea Month	ath Day	Year	3. Time of Death	
dica		Romald E. Jus	TIS		4h City Tayya a	A section of Dooth	//	22	07	5:05 AM	
ninei		4a. Facility Name (If not institution, give stre R Adoms Cowley Shock 7	ruma Ceni	ter	B_2	Location of Death		4c. C	ounty of Death		
al		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h V Year)	9. Birthp	place (State or Foreign	
or	-	210-32-3117	^{1 2□ F} 5	9 Yrs.	World Days	TIOUIS WIII.	10-29-		Mary	land	
	- i-	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				1	10d. Inside City Limits	
Ş	5	Maryland Harford		Bel Air					1 □Yes 2X No		
Euporal Director		10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code			10g. Citize	en of What Cour	ntry?	
2	9	728 MacPhail Court			21014			U.S.A.			
1		11. Marital Status 1 □ Never Married 2 Married	Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14	 Race - Americ Black, White, 		
		3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		s	Specify: Wh	ite	
200	2	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind	d of Business/In	dustry	
Elementary/Secondary (0-12) College (1-4or 5+)									•		
3	12 3 Account Executive Office/Sta									lonary	
a of		William M. Justis	III			Rosalie '	,		,		
	-	19a. Informant's Name/Relationship (Type.	Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Numbe	er, City or	Town, State, Zip	o Code)	
		Wilhelmia Justis	(Wife)		lacPhail (Air,	MD 2101	4	
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Rem	novai irom State		osition (Name of matory or other place	1	Date	20c. Loca	ation - City or To	own, State	
		4 ☐ Donation 5 ☐ Other (Specify)	. S		s Cemeter		6-2007		s, Mary		
ouce.	21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014										
		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	tions that caused the cause on each line.	death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	410	Approximate Interval Between Onset and Death	
n i		Immediate Cause (Final disease or condition resulting in death)	Traun	rafic br	un injure	1		The	nun	Oriset and Death	
al er		resulting in death)	Due to (or as a co	nsequence of):	1	r	1 Harry	MINEN			
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1 2		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				APPROV	16-				
ů	EXC	resulting in death) Last	Due to (or as a co	nsequence of):		CERTIFICA					
i i	enical Examine	d									
		IF FEMALE: 23c	. If yes, outcome pf p	regnancy				000	2d Date -6 d-15		
		23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnanc	у		23	3d. Date of deliv Month	Day Year	
Ohaninina (M.	l ys	9 Unknown	9□ Unknown								
2	۲ ک	Part II. Other significant conditions contri	buting to death but no	ot resulting in the u	ınderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to t	the cause of death?	
100	Completed by						1 🗆	Yes 2□	No 3∏ Pro	bably 4 Unknown	
2							24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of	
		22.14					1□ Yes	2 No	death? 1 ☐ Yes	211 No	
å	20	25. Was case referred to medical examinar? 1 □ Yes 2 □ No Hos	spital:	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Deat			□Other (Speci	(, a)	
F		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of			28d. Describe			rly)	
15	9150	1 Natural 5 Pending 2 Accident investigation	11/21/07	13:6		Yes 2 No	Motorce	cle	hit des	er.	
1		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (S	Specify)	reet, factory, office		City or To	wn, State)	Belo	ral Route Number,	
2	3	29a. Certifier 1 Certifying Physic	Stre		th occurred at the ti	me date and place	Rte. 54			e 136	
1	Medical Certification.	(Check only one)		amination and/or i							
N	ME	29b. Signature and title of certifier	111		29c. Licens	se number			signed (Month	, Day, Year)	
		· a mun	N MD		_	230			22/07		
4		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type	Street Rn	T2027	Q 11.		1117 717	0/	
State		31. Date filed (Month, Day, Year)	32. Registrar's	Signature .	STreet KN	1 101032	DZIRM	me,	11 211		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 17 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** EVELYN RUTH JOSKA NOVEMBER 27 2007 10:05 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1212 RUSTIC AVENUE ROSEDALE BALTIMORE If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1□M 2X F 11/11/1924 83 MD 218-12-4465 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Director Baltimore Rosedale 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 1212 Rustic Ave 21237 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Cashier 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Smith Katie (Unk) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Shay-Conover/Daughter 1212 Rustic Ave Rosedale MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 11/30/2007 Baltimore 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cvach / Rosedale Funeral Home 21. Signature of Funeral Service Lice isee 21237 1212 Chesaco Ave Rosedale MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) Completed by Be Certification: To

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760. within 24 hours after death

To the Funeral Director:
completely filled in by the

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Baltimore, Maryland 21215-0036

9 Unknown		9∟∪nknown							
Part II. Other significant co	enditions co	ntributing to death but not res	ulting in the underlyir	ng cause	given in Part I.	Ĭ		ise contribute to the cause of death? ☐ No 3 ☐ Probably 4 Ûnknown	
							24a. Was an autopsy performed? 1 Yes 2 Vo	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
25. Was case referred to m	edical				26. Place of D	eath (0	Check only one)		
examiner? 1 ☐ Yes 2 No	1	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	Home	5 Residence	6 □Other (Specify)			
	ending nvestigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c.	Injury at Work? 1 □ Yes 2 □ No	280	d. Describe how injur	y occurred	
	could not be letermined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fac fy)	ctory, of	fice	281	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		sician: To the best of my kno iner: On the basis of examina and manner stated.) and manner as stated. d place, and due to the cause(s)	
29b. Signature and tile of c	ertifie	111		29c. Lic	cense number		29d. Da	te signed (Month, Day, Year)	

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State Registrar

Medical

Kex 31. Date filed (Month, Day,

30-Name and address of person who co

NOV 2 9 2007

32. Registrar's Signature

pleted cau

FRANKLIN SQUARE DRIVE BALLIMORE MD 21237

se of death (Item 23a) (Type, Print)

Division or Vital Records, P.O. Box 68760,

Physician

Examine

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the <u>Medical Examiner must be notified at</u>

permit. Pages 1 and:
Department of Health
Important: if item 27
any injury or other tra

Physician

/Medical

Examiner

/Medical

Director

Funeral

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Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-tran physician the as IF FEMALE: 23b. Was decedent pregnant for ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by page 2 should certificate has 25. Was case referred to medical examiner? funeral director. Certification: To After this 27. Manner of Death Hospital or Attending death. 24 hours after death e Funeral Director: filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the I within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059107 m. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210_BUSINESS CENTER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2007 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** NOU 200 Robert E. Lee, Sr. 1611 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hanes Saltmor | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 24, 19 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs Maryland 213-44-9274 1943 **Director** 64 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-1 show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21228 USA 1924 Lismore Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1964-70 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White ρ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) System Budget Analyst Social Security Adm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany Injury or other traumatic event Be Robert Earl Lee Lillian Holtschneider ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1924 Lismore Lane; Catonsville, MD 21228 Wife <u>Lynne Lee</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 11/23/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or compifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DURUOME oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) (o puer law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 10 No The 1∐ Yes Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 BER/Outpatient 3 □ DOA Certification: To Division or 27. Mapher of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerai C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and tile of certifier 29d. Date signed (Month, Day, Year) D47353

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State 31. Date filed (Month, Day, Year)
Registrar

30. Name and address of person who

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32, Registrar's Signature

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completed cause of death (Item 23a) (Type, Print)

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goo Caton Avenue

Bultimore Mayland 21229

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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M	Physicia al Exami	an/	Decedent's Name (First, Middle, I	salyn Lenha	'' F	Roslyn Le	ahey		Date of Death Month D November 2	ay Year 5, 2007	3. Time of Death 0708 hrs		
Н			4a. Facility Name (if not institution, Bon Secours Hospital	give street and number)	1		Town, or Location nore City	n of Death		4c. County of D	1A		
	Funeral Director		214-50-4777 1	Sex 7. Age (In your Age (In your Age)	rs. last birthda	ay) If Und Monti		m Min	8. Date of Birth(July 6		Birthplace (State or preign Country) Tennessee		
	vlaryland 28a-f show any <u>d at once,</u>	or	Usual Residence of Decedent 10a. State 10b. County Maryland N	1/A 10c. C	City, Town or	Location	Baltin	ure			10d. Inside City Limits 1 Ves 2 No		
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2	rs after death with the Maryland ural", or items 23a or 28a-f she miner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorce	12. Was Decedent Ever in Armed Forces? 1 Yes 2 Noted If Yes, Give Year or Dates:		If Yes, spec	ent of Hispanic O ify Cuban, Mexica No specif	an, Puerto Rio		14. Race - Al White, et	merican Indian, Black, c. hite		
	hou hou	Completed t	15. Decedent's Education (Specific Elementary/Secondary (0-12)		1) 16a. De dur	ring most of wo	Occupation (Giverity of the Communication of the Co	T use retired	1)	6b. Kind of Busine	ess/Industry		
	D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than natic event, the Medical	Be	17. Father's Name (First, Middle, La Parley Nicle	est)			18.Moth	er's Name (F	irst, Middle, Ma	iden Surname)			
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	Baltimore, MC bernit. Pages 1 and 2 s Department of Health an Important; If Item 27		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State	Ob. Place of D crematory Metro	or other place	//	11/2	7/07	Catons vi	He, Maryland		
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×-34	hysician Medical ∠xaminer		23a. Part I. Enter the ☐ €ease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	mplications that caused the deteach line. a. Cocaine and na Due to (or as a consequence	rcotic			cardiac or re	espiratory arrest	t, shock, o' heart	Approximate Interval Between Onset and Death		
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NOU	of V ng Phys After thi uneral d	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)		me of Injury	28c. Injury at Wo			w injury occurred	Jules.		
#1-15man	i gafa	Certification:	1 Natural 5 Pendin Investig 3 Suicide 6 X Could r determ	gration FNd 11/25/20 28e. Place of Injury - A	At home, farm	n, street, factor	1 Yes 2 y, office building,	etc. 28	or Town, Sta	te)	or Rural Route Number, City		
#	To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician Check only	ined (Specify) othersician: To the best of my knowner:On the basis of examination		occurred at th		place, and du	ue to the cause(s) and manner as			
4	To the To the Comp	Medical	29b. Signature and title of certifier	and manner stated.			c. License numb				(Month, Day, Year)		
	Po f.		O.C.M.E. November 26, 2007 30. Name and address of person who completed cause of death Nem 23a)										
	Con		Zabiullah Ali, M.D. As	sistant Medical Exami	ner 111	Penn Stre	et, Baltimore	, MD 2120	01				
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	land .							

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Funeral				e (In yrs. last birthda			rs. 8. Date of Bir	th	Birthplace (State or Foreign	
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If a last 15-0050 filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
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ath w	ra	215 N. Chapel St			21231			USA		
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all yla		19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address (Street	and Number or	Rural Route Numb	er, City or Town,	State, Zip Code)	
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spita nours nera y fille			Physician: To the best							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	(Check only 2 Medical Ex	taminer: On the basis o and manner st		r investigation, in my	opinion, death o	ccurred at the time	, date and place,	and due to the cause(s)	
To the within To the Coral	Ň	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)	
	D31195 11/2							11/20	107	
17		30. Name and address of person wh	no completed cause of c	eath (Item 23a) (Ty						
4		Wendy Klopsz	6701 N		Sutt 420	2 70W	son read	211	4	
Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	d. 10.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 0040 AM Z007 arolyn 22 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NA JOHNS HOPKINS BALMMORE mi RAVVIEW MEDICAL CHT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🔀 F 254-70-2963 Ga. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 ☐ No NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 101 Center Place 21222 USA Apt. 315 Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 💥 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2 yrs. <u>Day Care Provider</u> Watch Me Grow Daycare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Dennis Elizabeth Truitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Oscar Murphy, 111 Son 4360 Parkside Dr., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-1-07 King Mem. Pk. Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner

Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.

Physician

/Medical

Examiner

10a. State

Md.

Director

Funeral

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Completed

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Funeral

Director

2 should be filed within 72 hours after death with the Marylan and Mental Hyglene.
is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed ending l been signed by the should be detached certificate has I rector, page 2 s ours after death.

neral Director: After this filled in by the funeral d

Division or Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner	disease or condition resulting in death) a. Due to (or as a consequence of the control of the c							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. UHEQINU CANCER List (Jassous Quinted) c. Due to (or as a consequence of): d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Parl I. 23e. Did tobacco use contribute to 1 Yes 2 No 3 P						o the cause of death? robably 4 □Unknown	
	24a. Was an autopsy performed? death? 1 Yes 2 N to 1 Yes						utopsy findings available completion of cause of	
Be	25. Was case referred to medical examiner?							
To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 ☐ Residence	6 □Other (Spe	cify)	
ation:	27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
dical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
dical C	29a. Certifier 1X CertifyIng Phy (Check only one) 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death occurration and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and du	s stated. e to the cause(s)	

29d. Date signed (Month, Day, Year)

11-22-2007

DHMH 17 Rev 1/2001

State Registrar

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BH711 8931

4940 EKTERN AVENUE, BALTIMORE, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 Duem ber Mary Louise Morgan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 82 23, 1925 South Carolina Director 066-26-9040 April Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3705 Baskerville Drive 20721 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black à 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. Homemaker Own Home and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Moise James, Sr. Roena Benjamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 i <u>3705 Baskerville Dr., Bowie, MD 20721</u> Rosalyn Smith (Daughter) Department of Hear Important: If Item? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/27/07 4 □ Defiation 5 □ Other (Specify) Faith Memorial Gardens Darlington, SC 22. Name and Address of Facility 21. Sign ture of funeral Service License Jordan Funeral Home sel 108 Lee St., Darlington, SC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or a a consequence of): **Physician** MAKNOWT disease or condition resulting in death) /Medical Examiner Maknown Coroline arythmiq Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy performed 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: A

J in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral Completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1043446 11.20.07 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 9801 Georgia

32 Registrar's Signature

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2007

ROINTAN FARAHIFAR

NOV 2 9

31. Date filed (Month, Day, Year)

Avi suit 3-41 Silver & pring

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 16:15PM Michael Messina NOV 2007 21 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hospital Baltimore St. Agnes N/A| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 24, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1XM 2□ F 215-66-4299 53 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Cedar Hill Road 21225 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Supplies Customer Service Rep. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Joseph Messina Barbara Dennis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah S. White, friend 128 Cedar Hill Road Brooklyn, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/30/07 <u>Baltimore, MD</u> 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb CM-MIL 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia 20 days disease or condition resulting in death) Due to (or as a consequence of) embolism 20 days Pulmonary Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? obstructive Sleep 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown morbid 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No obesity 24a. Was an autopsy performed' 2 **N**o 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Examiner MICHA Box 68760. attending p Vital Records, P.O. To the Hospital or Attending Physician: Division or within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

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an "natural", or items 23a or Medical Examiner must be

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permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic ew

Physician

/Medical

Baltimore, Maryland 21215-0036

Physician/Medical 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 Tes 2 No P 27. Manner of Death Certification: 1 Matural 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OP19513

Hospital, 900 S. Cuton Ave, Baltimore, MD 21229

29d. Date signed (Month, Day, Year)

NOV 21, 2007

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Faren

Fazeli

, MO

, St. Agnes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Parastoo

Something

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	Physici	ian	Decedent's Name (First, A									2. Date of De. Month	Dav	Year	3. Time of Death	
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VIII sicie	s certii lirecto	o Be	25. Was case referred to me examiner? Yes 2 No		lospital:	Inpatient 2	ER/Outpatier		Othe	_	of Death	Check only o		C [] () ()		
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DHMH 17 Rev 1/2001

State Registrar

			For State Registrar	State	f Marylan	•	artmen rtificate				-	giene	000	38147
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	Examin	er	4a. Facility Name (If not institution,	-	mber)		4b. City,		Location of	of Death		4c.	County of Dea	
			William Hill M 5. Social Security Number	anor 6. Sex	7. Age (In yrs.	last hirthday)	If Under		ston If Under	24 Hrs.	8. Date of Bir	th	Talbo	
	Funeral Director		212.18.6678	1 № M 2□F	86	Yrs.	Months	Days	Hours	Min.	Dec. 2	ıy, Yəar)	20 Mar	thplace (State or Foreign buntry)
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	death	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Ame	erican Indian,
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<u>B</u>			19a. Informant's Name/Relationsh Lana Parker/Dat			1.	17					-	r Town, State, . DE 19	
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Baltimore,	permit. Page Department Important: If any njury or once.		21. Signature of Laborro Service L	icansee	_	22	2. Name an	d Addres	s of Facilit	Aus	tin Roy	ster	Funera ton, DO	1 Home
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			shock, or hear failure. List of	complications that only one cause on e	aused the deat each line	h. Do not ent	er the mode	e of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Deathy
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687	death certificate be executed e attending physician and id for use as the burial-transit	edicai		d										
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o !	Physic this ce al direc	70 E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 🗆 DO	A Othe	r: 4⊘Nu	rsing Hor	ne 5□Resid	dence 6	6 Other (Spe	cify)
n O	ding Ph h. After th funeral	ion:	27. Mann of Death 1		of Injury th, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe I	how injur	y occurred	
Division	uttandii death. ctor: A y the fu	licat	2 ☐ Accident investigated as ☐ Suicide 6 ☐ Could not	ot be	of Injury - At ho	ome farm sto	M eet factory		es 2 □ !	-	28f Location /	Street and	d Number or R	ural Route Number,
<u>^</u>	of or Attand after death Diractor:	Certification:	4 Homicide determin		ng, etc. (Specifi		eet, lactory	, onice			City or To	wn, State,)	TOUTE NUMBER,
	To the Hospital or Attanding Physician: within 24 hours atter death: To tha Funaral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying	Physician: To the xaminer: On the b	best of my kno	wiedge, death	occurred a	at the time	e, date an	d place, a	and due to the	cause(s)	and manner as	s stated.
	To the H within 24 To tha F complete	Medical	uney	and man	ner stated.	tion and of in				ui occuire				
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			30. Name and address of person w	the completed call	se of death (Item	1 23a) (Tvna	Print)		00	1/2	<u> </u>	/ / /	10/	
	Ø		William H W	And Si. of	18479	ZZ	ina.	5 W	Vood	SI	Drive	F	aston	MD 21601
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			For State Registrar	State of Maryla			of Health			ene 00	7 38148	
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	Physici		Paula Narango					1	Month 1-22-20	,	5:07 P M	
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, To	own, or Location			4c. County of I		
	Lxamm	٠.	500 Cedar Spring Ro	d		Bel	Air			Harfor	:d	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday)		Year If Under Days Hours	Min.	B. Date of Birth	Year) 9.	Birthplace (State or Foreign Country)	
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	pur *	}	Usual Residence of Decedent 10a, State 10b, County	10c. 0	City, Town or Lo	cation					10d. Inside City Limits	
	sho	5	Maryland Harford		Bel Air						1 ☐ Yes 2 X ☐ No	
	288-1	Director	10e. Street and Number		DCI AII	10f. Zip 0	Code		10	g. Citizen of Wha	at Country?	
	with se or	₫	500 Cedar Spring R	d		21	015			U.S.A.		
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d 2	Hygic ther int,		17. Father's Name (First, Middle, Last)		DIIVII	- Inclied				laiden Sumame)		
an	id be ental ked o	To Be	Wladimir Omcikus				Pa	uline	Rauh			
2	nd M mar	-	19a. Informant's Name/Relationship (Typ	өө, Print)	19b. Mailir	ng Address (Street and Num	ber or Rural	Route Number,	City or Town, Sta	ate, Zip Code)	
Ž	alth a	1	Gina Shaffer (Atto	rney)	207	Fulfor	d Avenu	e Bel	Air, MD	21014		
Je Je	of He of He roth		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Re		. Place of Dispo cemetery, crei	osition (Name matory or oth	e of ner place)	Da	ite 2	0c. Location - Ci	ty or Town, State	
<u>Ĕ</u>	Page nent ant: if		4 □ Donation 5 □ Other (Specify)		ayview (re, Maryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 28a or 28a-f show Important: if item 27 is marked other than "heatical Exarcinating the notified at any nighty or other traumatic event, the Medical Exarcinating the notified at ange.		21. Signature of Funeral Service License		22 T.	2. Name and	Address of Fac	Schi	imunek F	uneral H . Air, M	ome of Bel Air	
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2	ding f	0	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,) Injury	M Z	3c. Injury at Work? 1 ☐ Yes 2		ou. Describe no	w inquity occurred	•	
Division of Vital Records,	for Attending efter death. Director: After in by the fune	ficat	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, st						or Rural Route Number,	
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 ☐ Certifying Physical Check only one) 2 ☐ Medical Examination	sician: To the best of my a ner: On the basis of exam and manner stated.	knowledge, deal ination and/or in	th occurred anvestigation,	at the time, date in my opinion, d	and place, a leath occurre	and due to the ca ad at the time, da	use(s) and manrate and place, an	ner as stated. id due to the cause(s)	
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			NA Car	Mu m	n		7279	75		11/22/	02	
	n		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type	, Print)	4					
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	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 9 2	007 32. Registrar's Si	gnature	prete	,			Mn		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day :30 NEUBAUER Jovember 24 2007 County of Death or Location of Death Name (If not institution, give street and number 4b, City, Town DURNIE NNE Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Days Months Hours Min. 1□M 2√F Maryland 214-26-6517 Feb 15, 1929 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☐ No Pasadena Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 100 S. Ritchie Highway 21122 <u>USA</u> Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: white 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>housewife</u> own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Schillinger Bernard Wingate Hayden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 358 Seahorse Court Annapolis, MD 21403 Thomas Neubauer/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Othe (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 June - Service Licens Ronald SZ Director Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month Due to (or as a consequence of): ear S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? en in Part I. 4 Hinknown 2 No 3 Probably 1 TYes

Physician /Medical Examiner Examiner requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f shov ns 23a or 28a-f shor must be notified at

items 23a

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permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natun any Injury or other traumatic event, the Medical once.

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Division or Vital Records, P.O. Box 68760,

Physician/Medical 2 Completed Be

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	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underl	ying cause giv
o Be Completed	25. Was case referred to medical examiner?	Hospital: 1 ☑Inpatient 2 ☑	ER/Outpatient 3	DOA Oth
ation: To	27. Man f Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo VI 1 □
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fy)	factory, office
Medical C	29a. Certifier 1 ertifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my known iner: On the basis of examination and manner stated.	owledge, death occ ation and/or invest	curred at the ti igation, in my
Me	29h. Signature and title of certifier	10		29c. Licens

	l .	
	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
26. Place of Death (Check only one)	
OOA Other: 4 Nursing Home	e 5 ☐ Residence 6	□Other (Specify)
28c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how injury	occurred
ory, office 28	f. Location (Street and City or Town, State)	l Number or Rural Route Number,
d at the time data and place on	ed due to the eques(c)	and manner as stated

(Check only one)	2☐ Medical Examiner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occurred at the	ne time, date and place, and due to the cause(s)
29b. Signature and	Hiller of certifier Stules to MY	29c. License number D 7 4 2 8 5	29d. Date signed (Month, Day, Year) November 24 200

	and Division of Atlanta Base Vessal
. License number	29d. Date signed (Month, Day, Year)
D 74285	November 24 200-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington BALTIMOIR

charles wiles his nter 301 Hospital Drive Medical Contar 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09168 State of Maryland / Department of Health and Mental Hygiene John A. Newman 38150 2007 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year November 26, 2007 1728 hrs A. Newman **Medical Examiner** John 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Clinton Prince George's Southern Maryland Hospital Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours 1949 Country) MD Director Sept 4, X X 2 F 219 58 8081 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 1 Yes 2 XXIo a or 28a-f show a Upper Marlboro George's Maryland Prince death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20774 2600 Sansbury Road items 23a 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 X Married _{Specify:}Black XX Yes 2 No 1968 Yes 2 X No specify: hours after Divorced Yes, Give Year 1970 "natural", <u>م</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) mit. Pages I and 2 should be filed within 72 partment of Health and Mental Hygiene. prortant: If item 27 is marked other than "ury or other traumatic event, the Medical. Dept of Works & Transporation Baltimore, MD 21215-0036 Truck 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice H.Windsor Be John A. Newman, S 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Sansbury Road, Upper Marlboro, MD 20774 Nakesha Newman (Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Clinton, Maryland Resurrection Cemetery 12/4/07 Donation 5 Other Speqify 22. Name and Address of Facility Lee Funeral Ilome, Inc 6633 Old 21. Signature of Funeral Service 963 Alexandria Ferry Road, Clinton, MD 20735 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure List only /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Caus-Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be 1 Yes 2 No 3 Probably 4 V Unknown ģ chronic alcoholism Completed 24b. Were autopsy findings available 24a. Was an certificate has been ector, page 2 should prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA this ို 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death fication: ✓ Natural Yes 2 No Pending Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME November 27, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

oth

31. Date filed (Month, Day, Year) State

Theodore M. King, Jr., MD.

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32. Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Prico 1248a M KOU 26 2007 Horace 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) NA Hopkins Hospital Baltmore Johns If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 XM 2□ F Months 218-36-2072 68 8-29-1939 Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 □ No Baltimore NA Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21205 910 N. Streeper Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Black Specify. If Yes, Givo-Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kay's Construction Construction Worker 5th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Price Woods Lola Horace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of Cemetery, crematory or other place) Barbara Price Da. Method of Disposition Md. 21205 City or Town, State 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cem. Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East l on 00 1101 E. North Ave. Baltimore, Md 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pheumonia 7 days disease or condition resulting in death) Due to (or as a consequence of): enal Failure Sequentially list conditions, and L. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Metastahl Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, ed by the a signed by t peen : page 2 s certificate this

Physician

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Pages 1 and 2 should be filed within 72 hours after death

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f Health and Mental Hygiene. Item 27 Is marked other than "natural", or I other traumatic event, the Medical Examir

permit. Pages 1
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Important: If ite
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once.

Physician

/Medical

Examiner

Examiner Physician/Medical þ Completed Be 2 Certification:

28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MD

enhaut The Johns Hopcins Hospital GOUN WOIFE ST 21287 31. Date filed (Month, Day, Year)

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NOV 26 7667

State Registrar

Medical

NOV 2 9 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Palmer Sturee 13, 2007 4:45 AM M Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Bradford Oaks Nursing Center Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year, **Funeral** 1 □ M 2 🛣 118-20-0701 89 09-06-1918 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Prince George's Fort Washington Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or 28a. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2112 Belfast Drive 20744 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ₩Widowed 4 Divorced Year or Dates: ed other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked other traumatic ev Bessie Freeman ၉ George Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2112 Belfast Drive, Fort Washington, MD 20744 William A. Palmer - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel Grove 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 11-16-07 Clover, VA Baptist 21. Signature of Funeral Service License 22. Name and Address of Facility Jeffress Funeral Home 2000 N. Main, South Boston, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Arteriosclerotic Heart Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 TProbably 4 TUnknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 2 **X**No 2□No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No ۴ After this funeral dir 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: ocmpletely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State Registrar

William T. Tanner, M.D.

31. Date filed (Month, Day, Year)

9

D. 11701 Livingston Rd., Fort Washington, MD
32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

D35206

November 14, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09149 State of Maryland / Department of Health and Mental Hygiene 2007 38153 Harvey A. Phillips Certificate of Death Reg. No 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last)
HARVEY AR Month Day November 26, 2007 1503 hrs Physician/ PHILLIPS, JR. ARKELL 'xaminer Mε 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Country) 5. Social Security Number 214-88-9355 Hours Min **Funeral** Months Days 5-11-1961 Yrs 46 Director 1 XM 2 F 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State 1 Yes 2 X No NOTTINGHAM BALTIMORE MD 10g. Citizen of What Country? hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number U.S.A. 21236 7528 MARKS AVENUE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Funeral 11. Marital Status Armed Forces? 1 Never Married 2 XMarried 2 X No Yes Specify: WHITE Yes 2X No specify: If Yes, Give Year Divorced Widowed Baltimore, MD 21215-0036
pemit. Pages 1 and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) HYDRAULTCS MECHANIC 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (LIPHART) ANN MARY PHILLIPS, SR. ARKELL Be HARVEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21236 BALTIMORE, MD 7528 MARKS AVE ROXANNE PHILLIPS/WIFE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11 - 30 - 07MIDDLE RIVER, MD HILL CEMETER 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 21237 ROSEDALE, MD 1211 CHESACO AVE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and rsician Death failure. List only one cause on each line. Acute alcohol intoxication iedical Immediate Cause (Final disease Examiner Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical W UNPENDED 27,28a-f, perME,g875, 1/4/08 TT physician a 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760, IF FEMALE Day Year Month Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the past 12 months? Live birth attending p Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Yes 2 No 3 Probably 4 ✔ Unknown Records, P.O. δ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy peen death? performed? No 2 certificate has ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ of Vital ospital or Attending Physician: hours after death. Residence 6 Nursing Home 5 examiner? DOA Hospital: Inpatient 2 CER/Outpatient 3 28d. Describe how injury occurred this 1 V Yes No 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: Yes 2 X No unk Natural Division Pending Fnd 11/26/2007 Fnd 2:15 pm Director: A 28f. Location (Street and Number or Rural Route Number, City 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Accident or Town, State) 7528 Marks Ave. Nottingham, MD 6 X Could not be 3 Suicide other-scene (Specify) within 24 hours at To the Funeral D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ORIGINAL

MARKET !

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Hem 23a)

2007

Day Xear

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 27, 2007

29a. Certifier 1

29b. Signature and title of certifier

Zabiullah Ali, M.D.

Medical

State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vear Gwendolyn Vivian 1257PM Peace Overber 23 200 /Medical City, Town, or Location of Death 4a. Eacility Name (If not institution, give street and number) 4c. County of Death Examiner HaNG LILMOYE 8. Date of Birth (Month, Day, Year) 1945 Mary Land 5. Social Security Number 6. Sex Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 → F Days Months Hours Min. 62 Director 212-44-0413 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examlner must be notified at 1 Yes 2 No Baltimore Director Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 801 Winters Lane 21228 USA filed within 72 hours after death v Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black. White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home s 1 and 2 should be filed wi Health and Mental Hygien tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Raymond Baker Olivia Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar.
Important: If Item 27 is r.
any injury or or or Rodney Peace (Son) 1425 Linclon Wood Dr., Baltimore, MD 21228 20b. Place of Disposition (Name of Batentino remains to share of the s 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/27/07 Loudon Park Baltimore, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21228 23a. Last Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COL /Medical Due to (or as a consequence of Examiner Sequentially list conditions Directo for as a consequence of). Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Dav signed by the at Id be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 this certificate has autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 □ DOA 1 Inpatient funeral Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No al or Attend s after death. completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records P.O. Box 68760,

3altimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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NOV 2

200 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 09 4a. Facility Name (If not institution) give street and number, aih /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secoures Hospital Baltimore n/a 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 2 Days Director 212-46-5553 63 1-1-1944 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f sh notified n/a Baltimore M∏Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. o ed 1931 W. Lafavette Avenue ral", or items 23a Examiner must b 21217 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify SpecifiAfrican-American 3 Widowed 4 N Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Baltimore City Public School Department of Health and Mental Hygis Important; if item 27 Is marked other any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William McClean Louise Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moana T. Powell/ Daughter 1931 W. Lafayette Avenue, Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12-3-07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1/36 N NUMBER STILL 21. Signature of Funeral Service Licensee UYLie Friend Home 23d. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOURS **Physician** OUT OF HOSPITAL CARDIAL ARREST /Medical Due to (or as a consequence of): Examiner CANDIO VASCULAR Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANDIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown ATHEROSCLERATIC MYOCARDIAZ INFARCTION 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 4a. Was an autopsy performed 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a Date of Injury 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier # D0066335 VOVEMBER 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAZTIMORE W. 2000

DHMF 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

32. Registrar's Signature

BALTIMORE MD

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teph	nen Queen		State of Maryland / Department of Health and Mental Hygiene I-For State Certificate of Death Reg. No. 2007 3815				
01:	Physicia	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 1804 bre				
ileai	ical Exami		Stephen Queen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death				
			University Hospital Baltimore				
	Funeral		5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign unk				
	Director		1X M 2 F 56 Yrs. Feb 20, 1951 Country)				
	any	ı	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits				
	* 1	5	MD Baltimore 1 X Yes 2 No				
)	e Maryl or 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 W. Franklin Street 21202 USA				
1001			11. Marital Status Unik 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,				
_	death with the ritems 23a	Funeral	1 Never Married 2 Married Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.				
	after aral", o	by F	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: black				
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]	1215-0036 d be filed within 72 hours after fental Hyglene. Inarked other than "natural", event, the Medical Examiner.		17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk				
,	- 5 6 6 9	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
	e, MD 1 and 2 sho Health and item 27 is		O.C.M.E. 111 Penn Street Baltimore, MD 21201				
	imore, MD 2 Pages I and 2 shou nent of Health and N iant: If item 27 is n or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State				
	Baltimore, permit. Pages I as Department of He. Important: If ite	ļ	4 Donation 5 X Other Specify: in state				
	Bal permi Depar Impo injur		21 Sig ure Fundral Sanice Licensee Ron S. Wade regto State Anatomy Board 655 W. Baltimore Street Ron S. Wade regto Raltimore MD 21201				
	Physician	1	23a. art I. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart littlere. List only one cause on each line. Approximate Interval Between Onset and				
3	/Medical 		Immediate Cause (Final disease a. Methadone and oxycodone intexication Death				
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
		iner	if any, leading to immediate Due to (or as a consequence of):				
	d iit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	calE	d. XUNPENDED AMENDED 29 6 ME 07/ 12/0//07 mm				
	60, ate be ex hysician e burial		XUNPENDED #23a,27,28a-f,perME,g874, 12/24/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery				
	Ox 6876 eath certificate attending phy for use as the l	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year				
	Box 6876 e death certificat the attending phy ed for use as the	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown 4 Pregnant at time or death 5 Other (Specify) 9 Unknown				
	P.O. It is that the gned by the detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?				
	S, P juires t en sign ild be d	ed b	24a. Was an 24b. Were autopsy findings available				
	cord law rec has bee	Completed	autopsy prior to completion of cause of performed?				
	tal Rec tian: The certificate ector, page		1				
	Division of Vital Records, lat or Attending Physician: The law requir at a fact death. al Director: After this certificate has been steed in by the funeral director, page 2 should t	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other: Other:				
	Ing Ph After t funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred				
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	Division of pital or / ours after teral Direction of the contraction o	Certification:	Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. Specify Nursing Home 28f. Location (Street and Number or Rural Route Number, City 501 W. Franklin St. Baltimore, MD				
	Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	To the Hospi within 24 ho. To the Fune completely fi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
		Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 12, 2007				
			30. Name and address of person who completed cause of death (Item 23a)				
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
	S Regis	tate	NOVER 1007 Mes Manufacture 1				
	7,6618	111	NUV 2 9 2007 Market 20 Mar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OSE 00 Month 2 Day 200° **Physician** EURGEN */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Months Days 1 □ M 2 X F 65 VIRGINIA Director 212-44-0280 JUL 18 1942 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 No **Funeral Director** BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. 6518 HILLTOP AVENUE 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💢 o Specify Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE SUN DOMESTIC 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (GRACIE HENDERSON AUBREY ROSE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6518 Hilltop Ave., Baltimore, Maryland 21206 Angela Rose/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE CEMETERY 12-04-07 BALTIMORE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signal re of Funeral Service Licens 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Que **Physician** MAI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of) Examine To the Hospitai or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? autopsy 2□ No 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide within 24 hours a To the Funerai D 1 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What C	Country?
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)		
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lary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street	and Number or Rura	al Route Number	r, City or Town, State,	, Zip Code)
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altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		cemetery	, crematory or other pla	ce)		·	
ıţ			4 □ Donation 5 □ Other (Special Signature of Fyneral Service Lice		Garriso	n Forest V			Owings Mil Reisterst	
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	/Medical Examiner			Due to (or as	a consequence o	f):				
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/	+1)		30. Name and address of person wh	completed cause of d	eath (Item 23a) (Type, Print)	e We	itmin	ter Mr.	21157
4	Sta	ite	31. Date filed (Marith, Par Year) 7	32 Registr	ar's Signature	derles	, ,		. •	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryle		tificate of l			No:2017	38159
-	Physici		1. Decedent's Name (First, Middle, Las David Ratcliff	it)				2. Date of Death Month NOVEMBER	Day Year	3. Time of Death 17 1:53A M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number) Medical Ce	enter	4b. Cify, Town, or	Location of Death	n	4c. County of Dea	
	Funeral Director		210-72-0030	ex 7. Age (<i>ln</i>)	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Apr 20,		thplace (State or Foreign ountry) yland
	land bw It		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Mary a-f shu tified a	ctor	MD		Baltimo	re				1 Yes 2 No
	th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 115 E. Melrose A				1212		. Citizen of What C	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba 1 □ Yes 2ሺ No	lispanic Origin? (S an, Mexican, Puert Specify:		14. Race - Ame Black, Whi	nite
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Maryland	hould I d Men marke matic	To Be	Norman William R 19a. Informant's Name/Relationship (19b Mailir	ng Address (Street		ine Overdo		Zip Code)
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or V	Physician: this certific	은	1 ☐ Yes 2 No		2 ER/Outpatier	II 3 DOA		Home 5 Residen		pecify)
ouo	ling After fune	tion:	27. Manner of Death 1 ★Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	Wo	ryat rk?]Yes 2∐No	28d. Describe how	injury occurred	
Division or Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, farm, str pecify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	e Hospital 124 hours a le Funeral pletely filled	ledical C	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, deat mination and/or ir	th occurred at the to	ime, date and plac opinion, death occ	e, and due to the car curred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
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			30. Name and address of person who KHOSROW TABAS			Print) SLER DF	RIVE. TO	OWSON. M	ARYLAND	21204
		ate	31. Date filed (Month, Day, Year)	\$2. Registrar's S			same g = 1 h		The same of the same	
	Regist	rar	NOV 2 9 200	1 States &	The Agreement	W.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38160 State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 25, 2007 Julia Ragland 5:05 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Spa Creek Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 F 223 14 5247 Usual Residence of Decedent | Virginia Aug 31, 1918 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland | Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2470 Shawnee Lane 20601 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, GiveX.X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3√Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor P.G. Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Sydnay Carpenter Annie Marks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Terry (Daughter) 2470 Shawnee Lane, Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Christ Episcopal Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signatur of Juneral Service Licenses Ferry Road, Clinton, MD

Physician /Medical Examiner

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Department of Important: If any injury or once.

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

Be

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each line.	Hahermi, Den	1	Interval Between Onset and Death
resulting in death)	Due to (or as a consequence of):		V PCV	10
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b			
that initiated events resulting in death) Last	c			
IF FEMALE:	d			23d. Date of delivery
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Part II. Other significant condition	ns contributing to death but not resulting in the	underlying cause given in Part I.		ouse contribute to the cause of death? 254% 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	
1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: Nursing Ho	ome 5 Residence	6 ☐Other (Specify)
27. Manner of Death → Ratural 5 ☐ Pending 2 ☐ Accident investig	ation	of 28c. Injury at	28d. Describe how inj	ury occurred
3 Suicide 6 Could n 4 Homicide determi		street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier Certifying (Check only one)	g Physiclan: To the best of my knowledge, dea Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
OOL Cignote's and this of partition		29c License number	29d D	Into signed (Manth, Day, Vear)

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State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cher L. My 216 (9

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #26,perMD,g873, 11/29/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 02:00a M /Medical BENJAMIN SMITH November 20 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 326 S DALLAS COURT BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1XM 2□F 79 Director MARYLAND 213-26-0626 DEC. 4 1927 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2/TXNo Director MARYLAND BALTIMORE CO HEREFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17354 BIG FALLS RD. 21111 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. RESTORIAN OF WOOD Elementary/Secondary (0-12) College (1-4or 5+) 12th grade CARPENTER Alth and Mental Hv. 7 Is mark. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ BENJAMIN K. SMITH SR. MARGARET DAVENPORT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 Is
any Injury or other trau
once. Blanche Smith/Niece 17354 Big Falls Rd., Hereford, Maryland 21111 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 KX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GOUGH U.M.C. CEMETERY 11-26-07 Cockeysville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Barbara Blown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCE /Medical Due to (or as a consequence of): Examiner Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division or Vital Records, P.O. been signed by the s should be detached to 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown けつ ロビに てどんらいか 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1☐ Yes 2 XNo this certificate 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Phosistones 6 Nother Specify's House 1 ☐ Yes 2 No To the Hospiral within 24 hours a let death.

To the Funeral Director: A fer this of the Funeral diffied in by the funeral director. Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mahudami 100057292 MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINDHU JAMES YORK ROAD SUITE 100 LUTIFUR VILL C mis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV29 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Michael Sauer Sr. 12:01 AM 29, 2007 November /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 3032 Dillon Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 ☐ F 84 10,1923 Maryland 216-12-8977 October Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hyglene. ordant; if them 72 is marked other than "natural", or items 23a or 28a-f show for order traumatic event, the Medical Examiner must be notified at Injury or other traumatic event, the Medical Examiner must be notified at 28a-f show Maryland N/A Baltimore 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3032 Dillon Street 21224-4942 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years <u>Transit Driver</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garland B. Bassford Marie Geyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7825 Chesapeake Road, Pasadena, Maryland 21122 Edward M. Sauer Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If i any Injury or once. Oak Lawn Cemetery Dundalk, MD. 4 □ Donation 5 □ Other (Specify) 1, 2007 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Fignature of Fufferal Service Lices ee r complications that caused the centh. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequency f): 7 minns /Medical Examiner Sequentially list conditions, it or y and it is to introduce the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician; The law requires that the death certificate be executed the burial-transit ang Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Atter (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendla within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

State Registrar 4 Homicide

(Check only

29b. Signature and title of certifier

10 Meinnuel 31. Date filed (Month, Day, Year) NOV 2 9 2007 32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 s. creene st Battimere, me

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

DOS79136

29d. Date signed (Month, Day, Year)

11-29-2007

21201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IVIA		tificate of Death	b	Reg. No 2 1 1 7	38163	
	Discontinuity		1. Decedent's Name (First, Middle, Last)			2. Date of De Month	ath Day Year	3. Time of Death	
	Physicia /Medic	al	Mary M	St	ricklin	Novemb		7 1.28 VM	
Ž.	Examin	21	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location Baltimore	n of Death	4c. County of Death		
-			Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under	er 24 Hrs. 8. Date of Bir Min. (Month, Da		thplace (State or Foreign	
1.5	Funeral Director		212-28-5856 ^{1□M} 2X F	77 Yrs.	Months Days Hours	Min. (Month, Da		yland	
	ס		Usual Residence of Decedent	40- City Town and a	antina			10d. Inside City Limits	
	show dat	_	10a. State 10b. County	10c. City, Town or Loc				1 ☐ Yes 2 No	
	he M 28a-f otifie	ecto	Maryland Baltimore 10e. Street and Number	Dunda	10f. Zip Code		10g. Citizen of What Co	ountry?	
	with ta or it be n	Funeral Director	310 Jeanwood Court		21222	2	USA	,	
	ms 23	Jera	11 Marital Status 12. Was Decedent 8	ver in U.S. 13. V	Was Decedent of Hispanic (f Yes, specify Cuban, Mexic		14. Race - Ame Black, Whit		
9	or iter	표	Armed Forces? 1 Never Married 2 Married 1 Yes 2 N If Yes, Give	ю і	i∏ Yes 2.5√No <i>Specii</i>		Specify:	le, etc.	
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed by	3¥ Widowed 4 □ Divorced Year or Dates:				16b. Kind of Business	hite	
7	n 72 h "natu edica	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired)	nost of working	Tob. Kind of Business	industry	
12	within iene. than " the Med	dwo	Elementary/Secondary (0-12) College (1-4or 5	+)	sewife		Own Home		
þ	e filed Il Hygi other /ent, t	BeC	17. Father's Name (First, Middle, Last)			ther's Name (First, Middle	, Maiden Surname)		
/lar	should be ind Mental i marked c umatic ev	일	Charles Henry Rode Sr.	T.		na Kuhn			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Nun North Point				
e, <u>~</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. It of Health and Mental Hygene. It is marked other than "natural" or items 23a or 28a-f show it is marked other than "natural" or items 20a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Stephen Stricklin so		sition (Name of matory or other place)	Date	20c. Location - City or		
Baltimore,	Pages nent of I ant: If its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		watory or other place) Valley Mem.	December 3, 2007	Timonium,	Maryland	
ŧ	+ せぜき	Ì	21. Signature of Funeral Service Licensee		Name and Address of Fac		Dundalk.P.A		
m	Depar Impo any ir		Enthony Con	melly.	110 Sollers H	Point Road, I	Dundalk,MD.	21222	
П			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ent e.	er the mode of dying, such	as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition					5 days	
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):	· · · ·	1 21		J	
	4	-	Sequentially list conditions,	Consequence of):	cont tibe	llation		3 years	
	ansit A	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated quants	e Hensian				10 heass	
o,	an and	Еха	that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
68760,	ficate be executed physician and stransit transit	edical	d						
_			IF FEMALE: 23c. If yes, outcome	of pregnancy			23d. Date of de	alivery	
Вох	eath certif attending for use as	cian	in the past 12 months?	2 Fetal death 3	⊒Ectopic pregnancy ∃ Other <i>(specify)</i>		Month	Day Year	
P.O.	the di y the iched	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown						
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or Vital Records,	equire en sig ould b					1	Yes 2 No 3 F	Probably 4 Unknown	
ecc	law re as be	Completed				24a. Wa	s an 24b. Were a prior to	autopsy findings available completion of cause of	
<u>=</u>		Соп				per 1□ Yes	ormed? death? 2 No 1 Ye	s 2 No	
Vita	Physician; r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: Hospital:		Other:	ace of Death Check onl			
0	Phys r this eral dil	- To	27. Manner of Death 28a. Date of Inju	ry 28b. Time o	IL 3 DOA 4	Nursing Home 5 Res 28d. Describe	how injury occurred	есіту)	
on	Attending Ph r death. ector: After th by the funeral	ition	1≱ Natural 5 □ Pending (Month, Da 2 □ Accident investigation	y Year) Injury	M 1 ☐ Yes 2	! □No			
Division	I or Attendi after death. Director: A	Certification:		ury - At home, farm, str c. (Specify)	reet, factory, office	28f. Location City or To	(Street and Number or Fown, State)	Rural Route Number,	
Ö	ital or A irs after ral Dire							/	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or ir	th occurred at the time, date nvestigation, i n my opinion,	e and place, and due to the death occurred at the time	e, date and place, and di	ue to the cause(s)	
	othe ithin i	Med	29b. Signature and title of certifier		29c. License numb	er	29d. Date signed (Mor	nth, Day, Year)	
	F S F O		1 Chitach P. Do	ila M	D. AT2438	3946	November	- 28,2007	
	V		30. Name and address of person who completed cause of c		Print)		, , , , ,	- 28, 2007 Baltimore, MD	
	- (erson Mi	D. Union	Memoral t	tospital	saltimore, MD	
	Sta	ate	31. Date filed (Mon 101 27) 9 2007 32. egistr	ar's Signature	state		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav NOVEMBER 19 DAVID 2007 Stokes 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALLMORE MARYLAND City of BAlhmore UNION MemoRIAL HOSPITAL If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Nov 4, 1959 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 W. 20th Street #2B 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: black 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Stokes Gloria Gladden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 E. Madison SStreet #604 Baltimore, MD Gloria Stokes/mother 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛣 Other (\$pecify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deam Immediate Cause (Final me how my tec disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 27. Manner of Dean 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide

P.O. Box 68760, or Vital Records, Division

the death certificate be executed this I Director: After to in by the funera or Attending death. after To the Hospital within 24 hours a To the Funeral [

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical E aminer must be notified at

72 hours after

filed withir Hygiene.

and Mental

permit. Pages 1 and 2.
Department of Health ar.
Important: If Item 27 is n.

Physician

/Medical

Examiner

burial-transi and

attending physician for use as the buria

signed by the a

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page 2 s

funeral

certificate

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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Completed

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Certification:

Medical

State Registrar

4 ☐ Homicide

29b. Signature and title

MULC

29a. Certifier

31. Date filed (Month, Day, Year) 2007

Wist

MW- 3333 NOV 32 Registrar's Signature

and manner stated.

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Mary R		rtificate of E		Re	g. N2 0 0 7	38165	
	Dhusiai		Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death	
	Physicia /Medic		Frances Shelton				Novembe	r 10, 200		
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	tsville		4c. County of De	George's	
ħ		-	St. Thomas More Nursing 5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.8	irthplace (State or Foreign	
	Funeral Director		577-64-5124 1□M 2∏F	59 Yrs.	Months Days	Hours Min.	(Month, Day, Sept 13	, 1948	ountry) unk	
yland	how		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
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vith th	or 28	Dire	10e. Street and Number		10f. Zip Code 200	0.2	1	ng. Citizen of What CUSA	Sountry?	
eath v	is 23a must	Funeral Director	1242 Florida Avenue NE 11. Marital Status unk 12. Was Decedent Ever i	n U.S. 13.	Was Decedent of His If Yes, specify Cuba		ecify Yes or No-	14. Race - An	nerican Indian,	
5-UU30 72 hours after death with the Maryland	t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	b	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1	If Yes, specify Cuba 1 ☐ Yes 2 【 No		Rićan, etc.)	Black, Wh	black	
13-C1:	n "natur Aedical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupa e kind of work done o DO NOT use retired	ition luring most of work)	unk	16b. Kind of Busines	s/Industry unk	
Z1Z1	Hygiene	Com	unk unk		1	18. Mother's Name	e (First Middle A	Maidon Surnamo)	unk	
	ked oth	To Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Nami	e (First, Middle, i	vialueri Surriame)	unk	
Mary d 2 shou	ilth and Mental 27 is marked or r traumatic ev	F	19a. Informant's Name/Relationship (Type. Print) St. Thomas More Nursing	I	ing Address <i>(Street a</i>			; City or Town, State	_	
Saltimore, permit. Pages 1 ar	permit. Pages 1 and Department of Health Important; if item 27 any injury or other to		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state	Db. Place of Dispo cemetery, cre	osition (Name of ematory or other plac		Date	20c. Location - City	or Town, State	
Baltil	Departme Importar any injur once.		21. Signature Funeral Service licensee Ronald Wade, Direct		2. Name and Addres tate Anato altimore.	-		Baltimore	Street	
			23a. Part I Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line.	death. Do not en	nter the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
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ited	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence of).						
68760, ficate be executed	physician and s the burial-transit		that initiated events c Due to (or as a cor	sequence of):						
58750 ficate be e	physic the bu	edical	d							
Box death cert	the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year	
s that the	signed by the a	by Ph	Part II. Other significant conditions contributing to death but no	t resulting in the I	underlying cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of death			
	been sig should b		Cerrainona, Breent		·		1 U Y	es 2⊡No 3□	Probably 4 Unknown	
		Completed	Diabetes Wellitra	•			24a. Was a autop perfor 1∐ Yes	sy prior death	eautopsy findings available to completion of cause of 1? es 2 □ No	
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ouc gille	After funer	tion:	1 ☑ Natural 5 ☐ Pending (Month, Day Ye.		Wor	k? Yes 2□No	Zod. Bosonio n	on injury cocurred		
Division or Vita	after death Director: d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury building, etc. (S	At home, farm, st pecify)	street, factory, office		28f. Location (S City or Tow		Rural Route Number,	
Hospita	4 hours Funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of management of examiner: On the basis of examiner and manner stated.	y knowledge, dea mination and/or i	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)	
Toth	within 2 To the complete	Me	29b. Signature and little of certifier	and	29c. Licens	e number	2	29d. Date signed (M VEVEUS	onth, Day, Year)	
			30. Name and address of person who completed cause of death	(Item 23a) (Type	e, Print)	ensbur	y Ed H	natisu	KR MD 81	
	St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Begistrar's NOV 2 9 2007	Signature	hade					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month November 14, 2007 **Physician** 7:30 PM M Margaret Virginia Schmidt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 37 Acorn Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🛱 F 216-14-1500 92 Jan 26, 1915 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter an once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2√ No Director Anne Arundel Annapolis MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 37 Acorn Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 □ Never Married 2 □ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. \$ 3K Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) state of Md secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Miriam Suite Guy Wilson Tucker 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15015 Shadown Creek Place Waldorf, MD Maren Sheidy/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate C use (Final disease or condition resulting in death) ouelovovascular disease Physician VVC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician after use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestoute Rd. Annapolis, and. Selonich, mo STUaut 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV29 Registrar 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:45PM Joseph Francis Stewart, Sr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AG NES HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2□ F 90 186-10-9499 Director Sept. 17, 1917 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits Baltimore r 28a-f sh notified MD Baltimore Highlands 1 ☐ Yes 2 ☐ No Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a any Injury or other traumatic event, the Medical Examiner must be notified. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2826 Hoffman Avenue 21227 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 NYes 2 No If Yes, Give 194 Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager/Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William John Stewart Mary Henratty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Kolscher/Daughter 323 Burns Crossing Rd. Severn MD 21144 20b. Place of Disposition (Name of Cemetery, crematory or other place)
MD Veteran Cemetery
Garrison Forest

Date
11-29-2007 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Fugeral Service Licensee There 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Poset and Dea HOUIS Immediate Cause (Final **Physician** SEPTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner URINARY TASIT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Indwelling Foler Due to (or as a consequence of): Box 68760 BPH Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an was autopsy performed? Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 0 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending 5 ☐ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Dires. 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) P20556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 Gaton AVE, BALTIMORE MD 21229 ILOVET. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

S

07-09007 Earl Shaffer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arl Shaffer		State of Maryland / Department of I	-lealth and Mental Hygi Death	iene Reg. N	
Physician		nistrar Decedent's Name (First, Middle,Last)		Date of Death Month Day November 21	3. Time of Death 2007 2007
ledical Examine	r	Earl F. Shaffer	D. City, Town, or Location of Death		4c. County of Death
	48	. Facility Name (ii not institution, give street and name)	Baltimore City		
Funeral	15.	Social Security Number 6. Sex 7. Age (In yrs. last birthday)			M/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		$219-22-0399$ ${}_{1}X_{M}$ ${}_{2}_{F}$ 80 ${}_{Yrs.}$	Months Days Hours Min.	April 2	6, 1927 Maryland
	U	sual Residence of Decedent			10d. Inside City Limits
v any		Da. State 10b. County 10c. City, Town or Location Halethorpe			1 Yes 2 No
faryland 28a-f show	5		10f. Zip Code	10g. (Citizen of What Country?
Mary or 28a		2839 Tennesse Ave.	21227		USA
death with the Maryland or items 23a or 28a-f sho must be notified at once.			Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - American Indian, Black, White, etc.
eath v r item	nue	Never Married 2 Married Armed Forces?	s, specify Cuban, Mexican, Puerto Ri	can, etc.)	
after o		or Dates:	Yes 2 X No specify: 's Usual Occupation (Give kind of wor	rk done 16	Specify: White b. Kind of Business/Industry
hours natur Exam		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use retired	d)	
36 hin 72 e. than than	ompleted		ctrician		Railroad
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f she continued the most be notified at once	5 1	7. Father's Name (First, Middle, Last)	18.Mother's Name (F		den Surname)
121; l be fil ental F arked	a L	Howard L. Shaffer 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Ru		r, City or Town, State, Zip Code)
MD 21215-0036 at 2 should be filed within 72 h th and Mental Hygiene. n 27 is marked other than "r numatic event, the Medical E	₽ 1	Michael Shaffer, son 1055	iO Anchorage Cove	Ln. Jac	ksonville, FL. 32257
Z p E g E	1	On Mathed of Disposition 20b. Place of Disposi	tion (Hame of comments)		Oc. Location - City or Town, State
AOFE ages 1 nt of F nt: If i	1	obstitution of Disposition The Burial Community of the Court of t		26-07	Baltimore, MD
Baltimore, permit. Pages I a Department of He Important: If ite injury or other trianger.		4 Donation 5 Other Specify: 11. Signature of Euneral Service Licensee 22. N	lame and Address of Facility Ambrose Funeral 1328 Sulphur Spr	Home. In	C
E PP W		3a. Part I. Enter the disease, or complications that caused the death. Do not enter the	1328 Sulphur Spr	ing Rd.	Arbutus, MD. 21227 shock, or heart Approximate Interval
Physician 'Madical	1	failure. List only one cause on each line.	ic mode of dying, each as the second		Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			
		Sequentially list conditions.			
		if any, leading to immediate Cause Enter Underlying Cause			
		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
0, be executed sician and burial - transit	핗	d.			
O, e be ex	edical	UNPENDED AMENDED			23d. Date of delivery
Division of Vital Records, P.O. Box 6876C urus alter death certificate ours after death. Real Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the b	Physician/M	noct 12 months?	etal death 3 Ectopic pregnar	ncy	Month Day Year
ox 6 ath cer attendi	Sicie	1 Yes 2 No 9 Unknown g Unknown	ther (Specify)		
b. B. the de ched f	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
P.C es that igned	by				2 No 3 Probably 4 Unknown
rds, requir	Completed			24a. Was ar autops	prior to completion of cause of
ecol he law ite has	d mc			perform 1 Yes 2	
ALR An: T	Be C	25. Was case referred to medical	26.Place of Death (Check of the state of DOA Other Nursin		tesidence 6 Other:
Vit;	임	examiner? 1 Ves 2 No 1 No pital: 1 Inpatient 2 ER/Outpatier 27 Nonper of Death 28 Date of Injury 28b. Time of	Injury 28c Injury at Work?	28d. Describe ho	ow injury occurred
n of ding P L. After funer?		27. Manner of Death 28a. Date of Injury (Month. Day Year) 28b. Time of 1604 hrs 1 Natural 5 Pending Nov 20, 2007	1 Yes 2 ✓ No	Driver of auto	involved in collision
Sion Attendi r death. ector: by the f	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, str.	eet, factory, office building, etc.	28f. Location (St	reet and Number or Rural Route Number, City
Division of Vital Records, P.O. sprital or Attending Physician: The law requires that th hours after death. Interal Director: After this certificate has been signed by Iffled in by the funeral director, page 2 should be detach	Certification:	Suicide determined (Specify) Local Street			ate) apsco Avenue , Baltimore City, Md.
		200 Cortifier	urred at the time, date and place, and	due to the cause	n(s) and manner as stated.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	one) 2 Medical Examiner:On the basis of examination and/or investig and manner stated.	29c. License number	at the time, date a	29d. Date signed (Month, Day, Year)
FSFO	ž	29b. Signature and title of certifier	O.C.M.E.		November 22, 2007
7		MILLER			
9+1		Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Person	enn Street, Baltimore, MD 2	1201	
	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	NP a		
Regis		NOV 2 9 2007 Marie A	de		

07-09011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Richard Schultz Certificate of Death 1- For State Registrar 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Day November 22, 2007 Physician/ 0450 hrs Richard Thomas Schultz, Sr. Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Baltimore N/AUniversity Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex oreign **Funeral** Months Days Hours Feb. 25. 1960 Country) MD 215-78-6984 1 X M 2 F Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Yes 2 X No MD Baltimore Lansdowne or items 23a or 28a-f show must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21227 United States 320 First Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White etc. Armed Forces? 1 Never Married 2 X Married Yes 2 X No Specify: White Yes 2 X No specify: Yes. Give Yea Divorced Widowed marked other than "natural", c event, the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Dermit Pages I and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked or injury or other train. Completed Elementary/Secondary (0-12) 9 Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melvina Blockinger Chester Schultz, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 320 First Avenue, Lansdowne, MD 21227 Deborah Schultz - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 11-27-2007 Baltimore, MD Loudon Park Cemetery Donation 5 Other Specify 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 2719 Hammonds Fry Rd., Lansdowne, MD even 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death Medica Heroin and alcohol intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Line Underlying Caus (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X AMENDED 3a.27.28a-f. X UNPENDED attending physician or use as the burial perME.g874. 23d. Date of delivery Box 68760 IF FEMALE: 23c. If yes, outcome of pregna Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown by the attraction q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 V Unknown ģ Division of Vital Records, P. 16 spiral or Attending Physician: The law requires the 24 hours after death. 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autonsy performed? death? has 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other examiner? Hospital: Nursing Home 5 Residence 6 2 V ER/Outpatient 3 DOA Inpatient this 1 🗸 Yes ဥ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of injury (Month, Day, Year) 28b. Time of Injury After 27 Manner of Death Certification: 1 Yes 2 y No 1 Natural Pending Fnd 11/22/2007 FNd 3:55 am the Fo the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State)
1537 Bush St. Baltimore, MD 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 6 X Could not be 3 Suicide determined (Specify) other-scene Δ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 23, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month Oay 32. Registrar's Signature De la Contraction de la contra State 9 200 Sales of Registra

10

Registrar

State

30. Name and address of Ley on who completed cause of death (Item 23a) (Type, Print)

MD. 100 32 Registrar's Signature

The state of

DC: M 31540

100 Invingst., NW. EB 3114 Washington, De 20010

Please Type or Print in Black Indelible Ink. Ensure Al	Il Copies Are Legible.
State of Maryland / Department of Health and M Certificate of Death	Mental Hygiene Reg. N2 0 0 7
	neg. NE. U U 7

		,	For State Registrar	State of Maryland / [Department of F Certificate of			iene	38171
54	Physici	an	1. Decedent's Name (First, Middle, Last,		Certificate of		Date of Deat Month	th Day Year	3. Time of Death
	/Medic	al	Betty Jo Schult: 4a. Facility Name (If not institution, give		4b. City. Town, o	r Location of Death	Novembe	er 27,200	
f	Examin	ier	Stella Maris Ho		Timoni			Baltimo	
0 4	Funeral Director		5. Social Security Number 213-28-7354 Usual Residence of Decedent	THE OFFICE	rthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3 – 1 4	Year) 9. Birt	hplace (State or Foreign untry) entucky
	yland now at		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	e Mar 3a-f st tiffied	ctor		/A Balt	imore				1 Y Yes 2 No
	a or 2 be no	Funeral Director	10e. Street and Number		10f. Zip Code	,	1	0g. Citizen of What Co	ountry?
	ns 23 must	era	2716 East Fairm	12. Was Decedent Ever in U.S.	13. Was Decedent of H		ecify Yes or No-	USA 14. Race - Ame	rican Indian,
9	or ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cubin	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc.
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	ed by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	. Decedent's Usual Occup	. 100		16b. Kind of Business/	ite
15	nin 72 n "nai Medici	plete	15. Decedent's Edu (Specify only highest grad		(Give kind of work done life. DO NOT use retired	during most of work d)	ing	100. Kind of business/	moustry
	be filed within 72 hours after death with the Marylar ttal Hygiene. dd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	12		Homemaker			Home	
and	I be filed valued Hygie	Be	17. Father's Name (First, Middle, Last) Bill Hatfield			18. Mother's Name	e (First, Middle, M Taylor	Maiden Surname)	
Maryland	s 1 and 2 should be f Health and Menta Item 27 Is marked o other traumatic ev	은	19a. Informant's Name/Relationship (T)	pe. Print) 19t	o. Mailing Address (Street			, City or Town, State, 2	Zip Code)
	nd 2		Brenda Schultz	- Daughter 38	310 Hudson	Street	Baltim	ore, MD 2	21224
Baltimore,	Pages 1 an nent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place o	of Disposition (Name of ery, crematory or other place			20c. Location - City or	
Itim	# 문문등		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		son Forest		_	Owings M:	ills, MD
Ba	permi Depa Impo any ir once.		Poles Loto	Jack L				ltimore,	al Home, PA
	44		23a. Part1. Enter the disease or compleshock, or heart failure. List only o	ications that caused the death. Do					Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition resulting in death)	MELANOMA					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):				
10	200	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):				
>	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):				
8760,	ate be executed hysician and the burial-transit	ical E		Due to (or as a consequence	or).				
9	death certificate be executed e attending physician and of for use as the burial-transit	ledic		1.					
Box	death certific attending p	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	n 3□Ectopic pregnanc	у		23d. Date of del	livery Day Year
P.O. I	the dea	ysic	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (specify)			World	Day Teal
	law requires that the de as been signed by the a 2 should be detached	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting i	n the underlying cause giv	ren in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
ords	equire en sig ould b	led b					1 □ Ye	es 2∏No 3∏Pr	robably 4XJUnknown
Records,	2 is a	Completed					24a. Was a	sy prior to	utopsy findings available completion of cause of
	in: The ificate ha		25. Was case referred to medical			00 Plans of Part	perform	2 X No 1 ☐ Yes	2 □ No
or Vital	Physician: r this certific ral director,	To Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Oth	26. Place of Death ter: 4 ☐ Nursing Ho		ence 6 X Other (Spe	cify) HOSPICE
0 1	ding Physician: The Ing. After this certificate he funeral director, page		27. Manner of Death 1 X Natural 5 □ Pending		Time of 28c. Injury Wor		28d. Describe ho	ow injury occurred	2001201
Division	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At home, fa		Yes 2 □ No	28f. Location (St	reet and Number or Ri	ural Route Number
<u>S</u>	n ji fe o	Sertif	4 ☐ Homicide determined	building, etc. (Specify)			City or Towr	n, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)	sician: To the best of my knowledgener: On the basis of examination ar	e, death occurred at the ti	me, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	o the vithin 2 on the omple	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licens	e number	2	9d. Date signed (Mont	th, Day, Year)
	->-0		1		12	437	_ ز_ح	11/271	(0)
	V		30. Name and address of person who co	ompleted cause of death (Item 23a)	(Type, Print)	, ,		11/01/	- /
			DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)	2300 DULANEY VA	ALLEY RD. T	IMONIUM,	MD 21093	3	
145	Sta Registr	~~	NOV 2 9 20	07	LEDBALL!				

State Registrar

1241

32 Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Brint) le St. Balto Md Z1208

07-09098
Robin Sitterly

Kobi	n Sitterly		State of Maryland / D 1- For State Registrar	epartment of the Certificate of L		/lental Hyg	giene Reg	No. 2007	38173
	Physici	an/	Decedent's Name (First, Middle,Last)		3. Time of Death				
ivied	lical Exami	ner	Robin Dorothy Sitterly 4a. Facility Name (if not institution, give street and number)	1 4h	. City, Town, or Loca		Month I November 2	24, 2007 4c. County of Death	1955 hrs
Ī	* 4		Maryland General Hospital		Baltimore			N/A	
	Funeral			yrs. last birthday)		f Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign	
	Director		219-88-1856 1 M 2XF 35	Yrs.	Months Days	TIOUIS IVIIII.	Aug. 1	5, 1972 Cou	maryland
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c	: City, Town or Location	1				10d. Inside City Limits
	Maryland 28a-f show datonce.	ō	Maryland N/A	Baltimore					1 X Yes 2 No
100	Maryl r 28a-i	Director	10e. Street and Number		10f. Zip Code	·-	10g	. Citizen of What Count	ry?
$\underline{\underline{\mathcal{C}}}$	vith the	al D	1307 Weldon Avenue 11. Marital Status 12. Was Decedent Eve	rin II S 13 Was	21211 Decedent of Hispani	ic Origin? (Spec	rify Yes or No-	USA 14. Race - Americ	an Indian Black
	death v r item nust be	Funeral	1 XXNever Married 2 Married Armed Forces? 1 Yes 2 XX	If Yes	, specify Cuban, Me			White, etc.	
	s after ral", o iiner n	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 1	es 2KX No sp			SpecifyWhite	
	2 hour "natu	ted	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)		S Usual Occupation (st of working life. DO			16b. Kind of Business/In	dustry
	036 rithin 7 ene. er than	Completed	12 2	Wai	tress			Restaur	ant
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Department of Health and Mental Hygiens. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other trauntatic event, the Medical Examiner must be notified at once.	ပိ	17. Father's Name (First, Middle, Last)			Mother's Name (F		· ·	·
	212 ould be Menta marke	To Be	Robert George Sitterly, S 19a. Informant's Name/Relationship (Type, Print)					ra Ivins er, City or Town, State,	Zip Code)
	MD and 2 should hand and 27 is aumati		Mildred Sitterly Mother					, Maryland	
	ore, es l an of Hea If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispositi crematory or other	r place)	<i>'</i>		20c. Location - City or 1	
	Baltimore, MD sernit. Pages 1 and 2 sho Department of Health and Important: If item 27 is njury or other traumati		4 Donation Other Specify: 21. Signature of Funeral Service Dec.	Metro Cre	_			Catonsville	
	Ba perm Depa Impo		\mathcal{A}_{i} \mathcal{A}_{i} \mathcal{A}_{i}	Bur	gee-Henss	-Seitz I	Tuneral	Home, Inc.	21211
	Physician		23a. Part I. Erryer the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter the	mode of dying, suc	h as cardiac or r	espiratory arres	t, shock, of heart	Approximate Interval Between Onset and
	/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)		xication				Death
			Sequentially list conditions b.	ince or):					
		iner	if any, leading to immediate cause. Enter Underlying Cause	ence of):				, 57	
	At in	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a conseque	ence of):					
	50, te be executed ysician and burial - transit	sician/Medical	X UNPENDED #MENDED, 28a-f		2/7/00 गग				
	760, cate be physic the bur	Med	IF FEMALE: 23c. If yes, outcome or	f pregnancy				23d. Date of delivery	
	Sox 6876 death certificate e attending phy for use as the l	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time	o of dooth	I death 3 E er (Specify)	Ectopic pregnand	СУ	Month D	ay Year
	Boy te death the att	Physi	aa						
	P.O. Bres that the designed by the be detached	5	Part II. Other significant conditions contributing to death but	t not resulting in the un	derlying cause giver	n in Part I.		acco use contribute to t	
	'ds, require seen sig ould be	Completed					24a. Was ar		opsy findings available
	Vital Records, ysician: The law requir his certificate has been a director, page 2 should	dmo	ļ 			-	autops perforn 1 ✓ Yes 2	ned? death?	ompletion of cause of
	tal Rection: The certificate ector, page	Be Co	25. Was case referred to medical			Death (Check or		NO TO TE	2 110
	F Vit Physici r this c al dire	10 E	examiner? 1 V Yes 2 No Hospital: 1 V Inpatient					Residence 6 Other:	
	nding I th. the funer		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Find 11/2///	28b. Time of Inj	, TV		ink ink	ow injury occurred	
	/isic	ficat	2 Accident Investigation TIU 11/24/2	2007 Fnd 7:55 -At home, farm, street,	bur l	ling, etc. 2	8f. Location (St	reet and Number or Rur	al Route Number, City
	Divided of the pital of the pit	Certification:	4 Homicide determined (Specify) Hote	el			110 W. No	rth Ave, Balti	imore, MD
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my known 2 ✓ Medical Examiner: On the basis of examina						
	To To con	Mec	and manner stated. 29b. Signature and title of certifier		29c. License nu			29d. Date signed (Mon	
			layure me chule		O.C.M.E	Ξ.		November 25, 20	07
1	6		30. Name and address of person who completed cause of death		nn Street, Balti	more MD 2	1201		
		tate		Signature #	-	more, MD 2	1201		
	Regis		1101/ - 0 2007	& Assert	,				

Richard Gerald Stulich, 3rd

		1- For State Registrar			С	ertifica	ate of	Death					Reg. No.			
Physici		Decedent's Name (First, Midd	2. Date of Death 3. Time (First, Middle,Last)									3. Time of Death				
ical Exami		Richard Gerald	ald Stulich III						Month D November 2					Day Year 0155 hrs 0155 hrs		
we do			stitution, give street and number)					c. City, To	wn, or Lo	ocation of				County o	f Death	
		Northbound 702 ramp	_		Essex				Baltimore Co			e Coun	ity			
Funerai		5. Social Security Number	6. Sex	7.	Age (In yr	s. last birt	hday)	If Under	1 Year	If Under	24Hrs.	8. Date of E	Birth (MM/	DD/YYYY		place (State or
Director		212-11-2235	1 X M	م ا	22		Yrs.	Months	Days	Hours	Min.	June :	23,19	985	Foreign Cour	
			1 X M	2F			115.									•
ž:	-	Usual Residence of Decedent 10a. State 10b. County			10c. C	ity, Town	or Location	n								10d. Inside City Limits
w any			1 + 4			unda]									- 1	1 Yes 2 XNo
Aaryland 28a-f show 1 at once.	ō		1timo:			unua	T	101 00					40- 000	zen of Wh		
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number						10f. Zip 0	222				USA		at Counti	ry?
the l		2473 Fairway						21					0.01			
with ns 23 be no	Funeral	11. Marital Status	12.	Was Deced		n U.S.						cify Yes or Nican, etc.)	10-	Race White		an Indian, Black,
leath	ű	1 XNever Married 2 N	Married 1	Armed Forc Yes	es r	0	"16	s, specify	Cuban,	IVICAICAIT,	rueitoit	ican, etc.)		Winte	, 0101	
fter of		3 Widowed 4 Di	vorced If Ye	s, Give Year	A		1	Yes 2	X No	specify:				Specify:	Whi	te
urs a Itura Amiu	d by	15. Decedent's Education (Sp.			completed	I) 16a.	Decedent	s Usual O	ccupatio	on (Give k	ind of wo	rk done	16b. l	Kind of Bu	siness/In	dustry
72 ho	Completed	Elementary/Secondary (0-12) (College (1-4	or 5+)	7	aunng mo	st of work	ing ille. i	DONOT	ase reure	u)				
336 thin 7. than edical	ם	12	ı			Ta	attoo	Art	ist				Si	ns of	the	Skin
d wil	S	17. Father's Name (First, Middle	e, Last)						18	8. Mother's	s Name (I	First, Middle	, Maiden	Surname)	
e file tal H ked o	Be (Richard G. Stu	lich	Jr.						Lis	a Ya	nnacc	i			
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	To	19a. Informant's Name/Relation	ship (Type,	Print)		19	b. Mailing	Address	(Street	and Num	ber or Ru	ral Route N	umber, C	ity or Tow	n, State,	Zip Code)
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygier and the Tile and the Maryland teath and Mental Hygier than "natural", or Items 23a or 28a-f 3the trannatic event, the Medical Examiner must be notified at once		Richard Stulio	h Jr.	-Fathe	er		22 Li	bert	y Pk	wy	Dun	dalk,	MD .	21222	<u> </u>	
nore, MD 21 ages 1 and 2 should nt of Health and Me 1: If item 27 is ma other traumatic ev		20a. Method of Disposition			20	0b. Place			e of cem	etery,		Date	20c.	Location -	City or T	own, State
MOFe, Pages 1 ar		1 Burial 2 X Cremation	on 3 R	emoval from			ory or oth	er place)		1	11/2	7/07	R	altim	2020	MD
timen trant		4 Donation 5 Other 3	Specify:			Metro		11/27/07 Balting 22. Name and Address of Facility Charles S.Zeiler								
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med		21. Signature of Funeral Service	e Licensee													ineral Home
		23a. Par / Enter the disease, o	r complicati	ons that cau	sed the de	eath Do n										Approximate Interval
Physician /Medical		failure. List only one caus	e on each lir	ne.		Jatin. Do ni	or ontor th					, ,		·		Between Onset and Death
-xaminer		Immediate Cause (Final diseas	_	tiple Injur												
		or condition resulting in death)	. Due	to (or as a co	onsequen	ce or):										
	ē	Sequentially list conditions, if any, leading to immediate	Due	to (or as a c	onsequen	ce of):										
	Ě	cause. Enter Underlying Caus				- 13										
_ =	Examin	events resulting in death) Last	Due	to (or as a c	onsequen	ce of):										
1760, freate be executed g physician and s the burial - transit			d				_									
e exe	n/Medical	UNPENDED	AN	MENDED												
8760, ificate be ig physic	₹	IF FEMALE:	the -	Bc. If yes, ou		oregnancy				7			23	d. Date of		. V
	au	23b. Was decedent pregnant in past 12 months?	1	Live birt	th nt at time o	C -1 1 -	2 Fet		3 _	Ectopic	pregnan	icy		Month	D	ay Year
Box 687 ne death certific the attending per the for use as the	Physiciar	1 Yes 2 No 9 U	nknown 9			oi ueau	5 Oth	ner (Spec	ify)							
he de y the	چ	Part II. Other significant cond				not resultin	a in the u	nderlying	cause di	iven in Pa	rt I.	23e. Dio	tobacco	use contr	ribute to t	he cause of death?
ires that the signed by	P.	Part II. Other significant cond	itions con	(ilbuting to t	Jean Dot	iot resultin	ig iii die d	nacity in g	oudoo gi			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_			ably 4 🗸 Unknown
S, F nires n sign d be			-							_		24a. W	20.20	124h	Were aut	opsy findings available
ords w requi	let	,								•		au	topsy		prior to co	ompletion of cause of
eco he law ite has	ompleted											1 ✔ Ye	rformed? s 2 1		death?	s 2 No
tal Rection: The certificate ector, page	ŭ	25. Was case referred to media	al					2	6.Place	of Death	(Check o	nly one)				
Division of Vital Records, P.O. Box 68 and or Attending Physician: The law requires that the death cert is after death. The All Director, After this certificate has been signed by the attendin led in by the funeral director, page 2 should be detached for use as	o Be	examiner? 1 ✓ Yes 2 No	Hosp	tal: 1 Ing	patient 2	ER/C	utpatient	3 D	DA [Other ₄	Nursing	Home 5	Resid	ence 6	✓ Other:	Scene
of Vir ling Physi After this	-	1 Yes 2 No		28a. Date of	f Injury	28b.	Time of I	njury 2	8c. Injur	y at Work		28d. Describ				
on of the standard of the stan	<u> </u>	1 Natural 5 Pe	nding	Nov 24, 2	007(1007)	015	1 hrs		1 Y	'es 2 🗸	No S	Subject d	river of	vehicle	ın ven	icular accident
SiC Atter	g		estigation	28e. Place	of Injury -	At home, f	arm, stree	et, factory.	office bu	uilding, et	c. :	28f. Locatio	n (Street	and Numb	er or Rui	ral Route Number, City
Divi	Certification:	de	uld not be termined	(Specify)							ı	or Town	i, State) 1702 rai	mp to Int	erloop 6	95, Essex, MD
ospits hour nners	1	4 Homicide	Dhualalani	To the best			oth occur	rod at the	time da	te and nis						
Div To the Hospital or within 24 hours afte To the Funeral Di completely filled in	Sal	(Check only one) 2 Medical E	enysician: (aminer:On	the basis of	examinati	on and/or	investigat	ion, in my	opinion,	, death oc	curred at	the time, da	ate and pl	ace, and	due to the	e cause(s)
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fi	To Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of t															
7	29b. Signature and title of certifier 29c. License number 29d. Date signed (<i>Month, Day</i> November 27, 2007															
		1 Kevoli	a No	/	7	XJI	4, -	V/2	0.0.1	*1.1.				, 5,11061		
— ,]		30. Name and address of pers						444.5	mm C1	4 D	Itim c	MD 040	001			
W		Theodore M. King, J		Assistar					iii S(r	eet, ba	numore	, MD 212	.01			
	State	11/01/19/	9 200	7 2000	jistrar's Sig	gnature	Box	Wed !								
Real	stra	a NUV &	O FOO	Design Con	dille and	100	10									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17, A M Tabron 2007 Minnie November 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reisterstown Future Care Cherrywood Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1□M 2☑F Director 212-40-2760 85 6, 1922 North Carolina Sept. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Ex miner must be notified at 1 ∑Yes 2 □ No Baltimore Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 West Belvedere Avenue 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: Black þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Blackmon ပ Berty Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Wise, Jr. / Son 109 Grange St., Rocky Mount, NC 27804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary Church Cem. 11/21/07 Bailey, NC 22. Name and Address of Facility
William Toney's Funeral Home
516 S. Poplar St., Spring Hope, NC 27882 21. Sign wre of Funeral Service Licensee Pah. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** unununa nowwy /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last be execut and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performs certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗆 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral (27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of pe

31. Date filed (Month, Day,

les

Year)

NOV 2

Medical

838

and manner stated

o completed cause of death (Item 23a) (Type, Print)

uman 32. Registrar's Signature

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Maniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09031 State of Maryland / Department of Health and Mental Hygiene Gregory Turner Certificate of Death 1- For State Reg. No Registrar 2 Date of Death Decedent's Name (First, Middle,Last) Month Day November 22, 2007 Physician/ 1923 hrs Medical Examiner TURNER GREGORY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltmore N/A Sinai Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 6 Sex 5. Social Security Number Foreign MARYLAND **Funeral** Months Hours Days Director 06/19/1964 XX M 2 43 213-92-6858 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County in y 1 X Yes 2 No 28a-f show BALTIMORE MARYLAND N/A Director 10g. Citizen of What Country? 10f Zip Code , or items 23a or 28a-f r must be notified at o 10e. Street and Number 21215 4058 EDGEWOOD RD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 XXNever Married 2 Married Yes 2XX No Specify: Yes 2 X No specify: BLACK f Yes. Give Year 3 Divorce Widowed event, the Medical Examiner "natural", ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) within 72 hours Completed Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 he Department of Health and Memtal Hygiene. Important: If item 27 is marked other than "na injury or other traumatic event, the Medical Exiting or other traumatic event, the Medical Exiting States of the Medical Exited States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the College (1-4 or 5+) Elementary/Secondary (0-12) U.P.S DOMESTIC 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GLORIA ANN ALEXANDER Be GRADY TURNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ို Edgewood Rd., Baltimore, Maryland Gloria Alexander/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XXBurial 2 Cremation 3 LANSDOWNE, MARYLAND 11/29/07 ZION CEMETERY MT. 4 Donation 5 Other Specify: 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee W NORTH AVENUE 1206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death Medical Heroin intoxication and cocaine use Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and ian/Medical X UNPENDED 4MENDED 7, 28a-f, perME, 9874, 12/13/07 TT attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Division of Vital Records, P.O. Box 68760, If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Physici 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 V Unknown by 24b. Were autopsy findings available Completed ficate has been si, page 2 should b 24a. Was an prior to completion of cause of autopsy performed? death? certificate has 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physiciau: 24 hours after death. Be Other₄ Nursing Home 5 Residence 6 examiner? Hospital: Inpatient 2 V ER/Outpatient 3 DOA After this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 Natural 1 Yes 2 Y No 5 Pending Fnd 11/22/2007 Fnd 6:50 pm Director: 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc in by or Town, State)
4058 Edgewood Rd Baltimore, MD X Could not be hours after 3 Suicide determined (Specify) found in residence within 24 hours a To the Funeral I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical the] and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 23, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD Day, Year) 32 Registrar's Signature 31. Date filed (Mo. NOV State 200 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VUUEMBER ZI, 180 Baby Boy Tarachand /Medical 4a. Facility Name (If not institution, give street and number **Examiner** Spita More onns 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ₹ M 2 □ F 21, Director 40 2007 Maryland none Nov Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 21236 USA 130 Sipple Avenue Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No asian Specify 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) none none none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Patranie Tarachand မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 ls Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street icensee . . Wade, nn Baltimore, MD 21201 rt1. Enter the dix ase, or conflications that Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immedia Cause (Final disease of a dition resulting in death) **Physician** 6 /Medical Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami ng physician and as the burial-tran Due to (or as a consequence of) attending physiciar by Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy jo in the past 12 months? Month Year Day 5 ☐ Other (specify) 1□Yes 2No detached the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should Completed Be Certification: To

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: completely filled in by the funeral director, within 24 hours a

		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 1 □ Yes 2 No				
25. Was case referred to medical	26. Place of Death	(Check only one)				
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	28d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	L yssician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)				

29c. License number

29d. Date signed (Month, Day, Year)

REET, BALTIMORE, MARYLAND 21287

State Registrar

DHMH 17 Rev 1/2001

Medical

29b. Signature and title of a

and manner stated.

			For	State of Maryland				Mental Hyg	jiene	
			1 - State Registrar		Cer	tificate of L	Death		eg. No?	1 38178
п	Physicia	an	Decedent's Name (First, Middle, Last)				Date of Dea Month	Day Year		
	/Medic		Lawrence Thomas			Novembe	7			
	Examin	er	4a. Facility Name (If not institution, give s	,		4b. City, Town, or		ath	4c. County of D	
	` <u></u>		Prince George's No. Social Security Number 6. Sex		st birthday)	Chever.	Ly If Under 24 Hr	s. 8. Date of Birth	9	George's
ю	Funeral Director			M 2□F 80	Yrs.	Months Days	Hours Mir		1927	Birthplace (State or Foreign Country) UNK
	ס		Usual Residence of Decedent							
	anylar show d at	-	10a. State 10b. County		Town or Lo					10d. Inside City Limits
	Ba-f s	Director		George's Di	stric	t Heights		T .		1 ☐ Yes 2 No
	with the a or 2 be n	١	10e. Street and Number 5028 Emo Street			10f. Zip Code	20747	1	0g. Citizen of What USA	Country?
	be filed within 72 hours after death with the Maryland at Hygiene. All Hygiene. did ther than "natural", or Items 23a or 28a-f show dither than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral		12. Was Decedent Ever in U.S	unk _{13.} v	Vas Decedent of Hi		Specify Yes or No-		merican Indian,
10	fter d r Iten iner	F.	1 Never Married 2 Married	I2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No				erto Rican, etc.)	Black, W	/hite, etc.
21215-0036	urs a al", o Exam	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 X No	Specify:		Specify: t	
5-0	72 ho natur dical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	ent's Usual Occupa	ation Jurina most of w	orkina i	16b. Kind of Busine	ess/Industry
7	ithin ne. han "	Jd L	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	9		
2	lied w Hygie her ti nt, th	ខ	unk u: 17. Father's Name (<i>First, Middle, Last</i>)	nk		unk	18 Mothor's N	ame (First, Middle, I	Maidan Surnama)	unk
and	d be fintal hed of	Be	17. Patriet's Name (1 list, Middle, Last)				TO. WOULEI S IN	ame (i iisi, wiiddie, i	viaiden Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentlet Hygiene. I importantent of the All and Mentlet Hygiene. Instructive, or ttems 23a or 28a-f show minportant: If the AZ is marked other than "natural", or ttems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ျှ	19a. Informant's Name/Relationship (Typ	pe. Print)	19b. Mailin	g Address (Street a	and Number or I	Rural Route Number	r, City or Town, Stat	e, Zip Code)
	and 2: ealth au n 27 is er trau		Prince George's Me	dical Center	3001	Hospital	Drive	Cheverly	MD 2078	35
re,	item item		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of natory or other place	i		20c. Location - City	
<u>E</u>	Pages nent of I ant: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 🔯 Other (Specify)	emoval from State						
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service License	ade, Director	22 S.t	. Name and Addres	s of Facility	-d 655 W.	Baltimore	Street
	90 E # 9		Xmn///	Me	Ва	ltimore,	MD 212	201		
			24 . Pa 1. Enter the dise se, compli sh . k, or heart failu e. List only on	cations that caused the death. le cause on each line.	Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
VI I	Physician		Immediatic Cause (Final disease or condition resulting in death)	Theocardia	u +	farelin	20.			Onoce and Doddi
	/Medical Examiner		resulting in death)	De to (or as a conseque	ence of):					
15		<u>-</u>	Sequentially list conditions, b	Lueur for as a conseque	ence of		=			
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	alpheiner	Do d	Knerch	á.			
o,	exec an and rial-tra	Exa	resulting in death) Last	Due to (or as a conseque	ence of):					
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9		Med	IF FEMALE:				U			
. Box	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
о О	he de the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5∟	Other (specify)				,
Records, P.O	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	, Ph	Part II Other significant conditions con	tributing to death but not result	ting in the ur	derlying cause give	n in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
ds	uires n sign ld be	d by	ahemia					1 □ Y	es 2∐No 3座	robably 4 □Unknown
S	w rec	lete	weight loss					24a. Was a	n 24b. Were	autopsy findings available to completion of cause of
R	The la	Completed			,	1444		- autops perfor 1□ Yes	med2 deat	to completion of cause of n? /es 2 \sum No
Vital	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or		
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n O	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Inju r y	Work		28d. Describe he	ow injury occurred	
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Division or	e Hospital or Attending 24 hours after death. e Funeral Director: After etely filled in by the funeral	Certification:	4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, iarm, siri	set, ractory, office		City or Tow	n, State)	r Rural Route Number,
_	spital ours neral filled		29a, Certifier 1 Certifying Phys	ician: To the best of my know	ledge, death	occurred at the tin	ne, date and pla	ce, and due to the o	ause(s) and manne	r as stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical Examination one)	ner: On the basis of examination and manner stated.	on and/or in	estigation, in my o	pinion, death oc	curred at the time, o	date and place, and	due to the cause(s)
	To the within To the comple	ğ	29b. Signature and title of certifier	٨		29c. License	number	2	29d. Date signed (M	onth, Day, Year)
			J	Wedne		194	7838	9	11-20	0-0-1
			30. Name and address of person who co	mpleted cause of death (Item:	23a) (Type, I	Print) D. A. M.	10000	lain x	VX ~ 26.71	ia .
	O	•	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re re	i ra la	mez	wix!	NO WITH	U
1.4	Sta Registr		NOV 2 9 2007	See See St	Com	20				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 21, **Physician** Haiq K. Tufenk 2007 8:45aM November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1**⊠** M 2□ F 477-22-7381 78 02/14/1929 MN Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County Show ms 23a or 28a-f shov must be notified at Washington 1X Yes 2 No DC: District of Columbia Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20020 USA 4413 Butterworth Place N.W. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner m 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examine ones. 1 Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Cryptologist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Mugerian Hampar Tufenk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 886 Hague Avenue, St. Paul, MN 55104 Armen Tufenk / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Snelling National 11/29/2007 Fort Snelling, MN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** y mor homa /Medical Due to (or as a consequence of) Examiner Nuemonia Sequentially list conditions, it as a bearing to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical the 88 IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 2 No 9 Hinknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2√ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed within 24 hours after death. To the Funeral Director: After this certificate 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA c 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide determined 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 ☐ Medicai E 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi

State Registrar

Atul Rohatgi M.D 31. Date filed (Month, Day, Year)

30. Name and address of perso

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

ORIGINAL

8000 Old Georgetown Road, MD 20814

70061307

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month ANNIE ENABLE NOVEMBER 21, 2007 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTING RE 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Da Date of Birth (Month, Day, Year, 8–7–1940 Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 💢 F 217-38-3.520 Md. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Md. NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2125 Sinclair Lane 21213 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 V Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled NA llth_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Venable Barber Rosetta Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28501 1368 Highway 55 East, Kinston, N.C. Sori Anthony D. Chapple, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11-30-07 Lansdowne, Md. Mt. Zion Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East B lade Won 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ACUTE RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) TWELVE DAY Due to (or as a consequence of) THREE BINTERSTITIAL LUNG DISEASE - SUSPECTED MUNTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): RHEUMATOID LUNG that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INTRADUCTAL PAPILLOMA 1 🔲 Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intel file 23 acr 28a-f show mit: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

and attending physician as the the

Examiner Physician/Medical Completed Be

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day, Year)

Medical Certification: To

Hospital or Attending Physiclan: The law requires that the death certificate be executed completely filled in by the funeral s after death. within 24 hours a To the Funeral I

Division or Vital Records, P.O. Box 68760.

the 10

State Registrar

5 ☐ Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury

28b. Time of (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of cortific

RES- 000

29d. Date signed (Month, Day, Year) 2007

NOVEMBER 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSE LUIS LUPEZ 4940 EASTERN AVENUE BALTIMORE MD MP.

NOV 2 9 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Day Year Llewellyn Husketh Walker /Medical 2007 6:09a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1619 N. Caroline Street Baltimore NA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-7-[9]] Birthplace (State or Foreign Country) Months Days Hours Min 214-40-4090 96 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 619 N. Caroline Street 21213 US'A Funera 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 I 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify: ģ Specify: Black 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 6 + yrs.Reading Specialist Baltimore City Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Husketh Joseph Lovey Lee ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lance H. Walker Son 1033 W. Barre Street, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat. Cem. 11-29-07 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Lad W 1101 E. North Ave., Baltimore, Md. 21202 ane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cas 7 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perfori 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home Spesidence 6 ☐ Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, has certificate Physician: this

burial-trai the as nse for detached page 2: filled in by the funeral director. or Attending Director:

Funeral

Director

show

r 28a-f show notified at

an "natural", or Items 23a or Medical Examiner must be

filed within 72 hours after

I Hygiene.

12 should be filed w h and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic events.

Physician

/Medical

Examiner

the

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C Hospital completely

State Registrar

cal

4 ☐ Homicide

31. Date filed (Month, Day,

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title was)

29c. License number

) o (mon)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) 20

Year)

9

NOV 2

MO 135 0/4

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Alyce Neal West November 21, 2007 Facility Name (If not institution, give street and number) Crofton Convalescent & 4b. City, Town, or Location of Death 4c. County of Death Rehabilitation Center 5. Social Security Number 6. Sex Crofton Anne Arundel 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 K Months Days Hours 244-22-8647 83 3-7-1924 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD P: 1 XYes 2 No Prince George's Bowie 10f. Zin Code 10g Citizon of What Country?

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

Physician

/Medical

Examiner

Funeral

Director

attending ph I for use as the page 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

Division or Vital Records, P.O. Box 68760,

Ö				7511 219 5545	1	iog. C	THEOR OF WINDLE OF	ountry :
, co	12304 Millstream	Drive		20715		U	ISA	
Be Completed by Funeral Di	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. W	as Decedent of Hispanic Origin? (S Yes, spedfy Cuban, Mexican, Puer	specify Yes or No to Rican, etc.)	o-	14. Race - Ame Black, Whit	
d by	3 AWidowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No Specify:			Specify:	White
plete	15. Decedent's Edu (Specify only highest grad	de completed)	(Give k	ent's Usual Occupation ind of work done during most of wo O NOT use retired)	rking	16b. l	Kind of Business	/Industry
E	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	emaker			Own Home	ρ
Se C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle			
To E	Sylvestor Edwar	d Tolar		Pear1	Ann Str	ick1	and	
Ñ	19a. Informant's Name/Relationship (Ti	ype. Print) 19	b. Mailing	Address (Street and Number or Ri	ıral Route Numb	er, City	or Town, State, .	Zip Code)
	Holly West-Owen-D	aughter 1	2304	Millstream Driv	e, Bowie	∍, M	D 20715	5
	20a. Method of Disposition 1 ★ Burjal 2 ★ Seremation 3 ★ Figure 2	20b. Place of	of Disposi	tion (Name of atory or other place)	Date		ocation - City or	Town, State
	4 □ Donation 5 □ Other (Specify,		ck Ce	metery 11-2	26-2007	Н	ope Mill	s, NC
	21. Signature of Funeral Service Licens	Tellen		Name and Address of Facility Ha				ral Home 348
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do	not enter	the mode of dying, such as cardia	or respiratory a	ırrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Metabolic						Onset and Death
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ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Digher lens v		andiomyop	athy			-years
ᆵ	cause. Enter Underlying Cause (Disease or injury that initiated events	Demoisstia	Ĺ	30.50				I Para 8
Exa	resulting in death) Last	Due to (or as a consequence					10000	
lical		Stroke						weeks
/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy					23d. Date of del	livan
Physician/Medical Examiner	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		ctopic pregnancy Other (specify)			Month	Day Year
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0	1 163 2 100	Hospital: 1 ☐ Inpatient 2 ☐ ER/O		3 DOA Other: 4 Nursing H			6 □Other (Spec	cify)
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ertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, fa building, etc. (Specify)	arm, stree	t, factory, office	28f. Location (City or Tox	Street ar	nd Number or Ru e)	ural Route Number,
Medical Certificat	29a. Certifier (Check only one) 1 Certifying Physical Exami	sícian: To the best of my knowledgener: On the basis of examination and manner stated.	e, death o	occurred at the time, date and place stigation, in my opinion, death occu	, and due to the rred at the time,	cause(s date an	s) and manner as id place, and due	s stated. e to the cause(s)
ME	29b. Signature and title of certifier	anond r	10	29c. License number D 2 0	08	29d. Da	ate signed (Month) $1/23/$	h, Day, Year)
-	30. Name and address of person who co	completed cause of death (Item 23a) RAMD 1430	(Type, Pr			Bo	WIFA	11) 20715
	31. Date filed (Month, Day, Year)	32. Registrar's Signature						

DHMH 17 Rev 1/2001

10

State Registrar

			For State	State of Mar		artment of I <i>rtificate of</i>		Mental Hy	(2007	38183
			Registrar 1. Decedent's Name (First, Middle, La	st)	Cei	runcate of	Dealli	2. Date of D	Reg. No.		3. Time of Death
Zgr.	Physici		Ruth	T	Wi	illiams		Month Novemb	Day	Year 2007	4:00 P M
4	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			or Location of Dea			County of Death	
			6803 Middlefield			Fort Wa	shington	1	Pr	ince Ge	
Е	Funeral		5. Social Security Number 6. S	□M 2KTE	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs Hours Min	(Month, D	irth ay, Year)	Cou	place (State or Foreign intry)
	Director		577-30-5004 Usual Residence of Decedent	9	5			12-28-	-1911	Vir	ginia
	yland how at		10a. State 10b. County		0c. City, Town or Lo						10d. Inside City Limits
	e Mar 3a-f s tiffied	ctor	MD Prince G	eorge	Ft. Washi	ngton					1. X Yes 2 □ No
	vith th	Director	10e. Street and Number			10f. Zip Code				en of What Cou	intry?
	sath v	eral	6803 Middlefield	Road 12. Was Decedent Eve	rin II C 12 3	20744		Passify Van an N	USA	A 4. Race - Ameri	one Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		rto Rican, etc.)		Black, White,	, etc.
Maryland 21215-0036	2 hour atura cal Es	ted t	15. Decedent's E	ducation	16a. Deced	dent's Usual Occu	pation		16b. Kin	d of Business/Ir	
215	hin 7% e. an "n Medi	plet	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done DO NOT use retire	during most of wo ed)	orking	1		,
2	ed wit ygien er th	Con	8		Dom	nestic			Ног		
and	be fill d oth even	To Be Completed	17. Father's Name (First, Middle, Last, James Goode)			18. Mother's Na Ann And	me (First, Middle	e, Maiden S	Surname)	
ž	hould d Mei marke	2	19a. Informant's Name/Relationship (Type Print)	19h Mailir	ng Address (Street			har City or	Town State 7	= Code)
<u>⊠</u>	nd 2 s lith an 27 is rtrau		Althea L. William	**		3 Middle				,, -,	
Ē,	other		20a. Method of Disposition		20b. Place of Dispo			Date		ation - City or T	
Ē	Page nent c ant: if		1X Burial 2 □ Cremation 3 □ 4 □ Donatjon 5 □ Other (<i>Specil</i>	Themoval IIOIII State	Bellevill		!	25-07	Suffe	olk, VA	
Baltimore,	permit. Departr Importa any inji		21. Signature of Funeral Service Licer		ome 1vd., Po			23704			
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<u>,</u>	n and	Examiner	that initiated events resulting in death) Last	Due to (or as a c	<u> </u>	ulbease					
68760	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	edical		d. Hyperte	nsion						
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Box	leath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 □ Live birth 2 [4 □ Pregnant at tim	Fetal death 3	Ectopic pregnance Other (specify)	y		23	3d. Date of deliv Month	ery Day Year
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<u>₹</u>	sician; The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		O#	or:	ath (Check only			
Ö	Phys r this ral dii	는 1	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien	IL SLI DOA	4 □ Nursing I	Home 5 X Res 28d. Describe			fy)
<u>0</u>	nding I th. : After s funer	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury	Wo	rk? Yes 2∐No	200. 2000.00	now injury	oodiica	
Division	i or Attend after death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home, farm, stre Specify)	eet, factory, office		28f. Location ((Street and iwn, State)	Number or Run	al Route Number,
5	itai or rs afte rai Dii	Cert		building, ctc. (Ony or ro	wii, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of n niner: On the basis of ex and manner stated	amination and/or in	n occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) a , date and p	and manner as s place, and due t	stated. to the cause(s)
	To ti Comj	Ž	29b. Signature and life of certifier		/	29c. Licens Wash	ington,	DC	29d. Date	signed (Month,	Day, Year)
			Thomas	Tund	er	1012			11-2	26-07	
	5		30. Name and address of person who				. DO 00	017			
	Sta	te.	Thomas Pinder, M 31. Date filed (Month, Day, Year) NOV 2 9 20	D II60 Var	num St. W Signature		n, DC 20	01/			
	Registr	ar	NOV 2 9 20	07 January	AS AGON	BACK S					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:40 PM Physician Donald Scott Warehime 2007 NOV. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6-28-1958 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 49 Pennsylvania 216-70-0296 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event. 3829 Yolando Rd. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 X Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ò Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Leroy Warehime C. Jean Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3829 Yolando Rd. Baltimore, MD 21218 19a. Informant's Name/Relationship (Type. Print) Kevin T. Kidd (partner) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 tment of I 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 11-26-2007 Baltimore, Maryland Bavview 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 6 9705 Belair Rd Nottingham, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a conservance of): disease or condition resulting in death) minutes /Medical Examiner Cronary e aquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine and resulting in death) Last Due to (or as a consequence of): Box 68760 physician s the burial certificate be Physician/Medical use as thending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No P.O. 9□ Unkлown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1□ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3□ DOA P 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0061310 Movember 25,2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · Ulman Memarial Katik Hernna N.O.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrer		State of Ma	aryiano		riment of F tificate of	Health and N <i>Death</i>	• '	_	2007	38185
1	Discontinu	4	1. Decedent's Name (Fin	irst, Middle, Last,			***			2. Date of Dea			3. Time of Death
	Physicia /Medic		Dorothy Agn	nes Wagn	er					11	19		8:36 P M
	Examin		4a. Facility Name (If not	institution, give	street and number)			4b. City, Town, o	r Location of Death		4c.	County of Deat	h
			Gilchrist C					Tows		T		Baltimo	
ß	Funeral		5. Social Security Number	4.0		e (In yrs. las 77	st birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birt	hplace (State or Foreign untry)
ļ.	Director		218-26-5291 Usual Residence of Dec	L						10-01-	1930	Mary	Land
	/land ow			b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mary Fied	tor	MD Ba	altimore		Per	ry Hal	L1					1 ∐Yes A∏No
	r 28a noti	irec	10e. Street and Number					10f. Zip Code			10g. Citi	zen of What Co	untry?
	th wit 23a o ist be	Funeral Director	9606 "H" Am	nberleig	h Lane			21128			1	USA	
	ems er mu	iner	11. Marital Status		12. Was Decedent I Armed Forces?		13. W	as Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
36	or it	y F.	1 Never Married	41	1 ☐ Yes 2 X N If Yes, Give	No		□Yes 2X No	Specify:	,,		Specify:Whi	
ö	hours turai"	d by	3 Widowed 4		Year or Dates:		16a Doord	ent's Usual Occup	nation		10h Ki	nd of Business/	
5	in 72 i "na' ledici	Completed	(Specify or	Decedent's Edu only highest grad	e completed)	- 4	(Give k	aind of work done O NOT use retire	during most of work d)	ing	TOD. KI	nd of business/	industry
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ılar	uld by Venta rked ric ev	To E	Edward Albe	ert Poff	el				Marguer:	ite Schu	ıltz		
ar	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/		_				and Number or Rur		-		
₹.	s 1 and 2 and 1 an		Michael Wag		n) 				oring Rd 1				
Baltimore, Maryland 21215-0036	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cro		temoval from State	20b. Pla	ce of Dispos netery, crem	ition (Name of atory or other pla	ce) ;	Date		cation - City or	
Ë	t. Pa tmen tant; ijury		4 Donation 5 □	Other (Specify)		St.			ton 11-23	3-2007 B	alti	imore, N	laryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funera	al Service Licens		ess of Facility Sch	imunek ingham,	Fune MD	eral Hom 21236	nes,Inc.			
	<u> </u>		23a. Part1. Enter the di shock, or heart fail	isease, or compl	ications that caused	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between			
U.	Physician		Immediate Cause (Final disease or condition		1506	z m		ardior		toxy			Onset and Death
	/Medical Examiner		resulting in death)		ue to (or es	a conseque	nce of):		1				
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Box	attending	an/N	IF FEMALE: 23b. Was decedent preg	griani	3c. If yes, outcome 1□Live birth	pf pregnand		Ectopic pregnanc	v		2	23d. Date of del	
<u>.</u>	ed for	Physician/M	in the past 12 mon 1 🗆 Yes 2 🕽 No	nths?	4□Pregnant at			Other (specify) _	y			Month	Day Year
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ŝ	res th		Part II. Other significant		to dista		ng in the un	deriying cause giv	en in Part I.	23e. Did to			the cause of death? obably 4 Unknown
Ö	requ	eted	Voll and -	7 700	1 OIS EN							110 2011	obabiy 4 Dollatiowii
3ec	e law has t je 2 s	Completed by			-					24a. Was autop		prior to o	topsy findings available completion of cause of
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₹	sicial certii recto	Be	25. Was case referred to examiner? 1 ☐ Yes 2 📉 No	-	fospital:	- 0000	7/0:	3D DOA Oth	26. Place of Death			.	1 - 6
ō	Phy r this eral d	٦. ا	27. Manner of eath		1 ☐ Inpatie	ry 2	R/Outpatient 8b. Time of	28c. Inju	4 □ Nursing Ho	me 5 ☐ Hesic 28d. Describe h		/	city) WOSPIR
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Division or	or Attending Phys after death. Director: After this in by the funeral di	ifica		Could not be determined	28e. Place of inju	ry - At hom	e, farm, stre	et, factory, office		28f. Location (S City or Tox			ıral Route Number,
Ō	Ital or rs after ai Dil	Certification:		<u>. </u>	Delianig, ox	(Opoony)				Only or You	m, oraco,		
	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	edical			sician: To the best on ner: On the basis of and manner sta	examinatio							
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	10	Ì	30. Name and address of	of person who co	mpleted cause of de			rint)	Dala	10 7	1200		20 2007
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07-08845

George Walls		State o	f Print in Bi of Maryland /							egible.		07 00	
		1- For State Registrar		Cei	rtificate d	of Deat	th			Reg. No.	20	07 381	8
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()		Northwestern Hospital Cent	,				lalistown		ou i		altimore C		
Funeral		5. Social Security Number unk 6. Sex	7. Age	(In yrs. la	ast birthday)	If Und	er 1 Year	If Under 24	Hrs. 8. Date of E	Birth (MM/D	D/YYYY) 9.	Birthplace (State or Fo	reign
Director		1X N	/ 2 F	76	Y	Month	ns Days	Hours N	Oct 3			Country) UT	1K
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w any		10a. State 10b. County	l l	•	Town or Loc							10d. Inside City Lin	
laryiand 28a-f sho at once.	to	MD Baltimo	re	Ra	ındal1s							1 Yes 2 X	No
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21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she cevent, the Medical Examiner must be notified at once.	al		12. Was Decedent E	verin II	Sim ld 13 W	las Docado			Chooles Voc or h	la 1			
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5-0036 led within 72 hours al Hygien of the matural other than "natural the Medical Examin	ջ	15. Decedent's Education (Specify only	r highest grade com	oleted)					of work done un	k 16b. Ki			ınk
16 n 72 h nan "n ical E	Set	Elementary/Secondary (0-12)	College (1-4 or 5	+)	auring	most of wo	rking lite. L	OO NOT use	retirea)	ł			
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21215-0036 unid be filed within 7 Mental Hygiene. marked other than c event, the Medica	امه	17. Father's Name (First, Middle, East)				u	ınk 18	.Mother's Na	me (First, Middle	, Maiden S	iurname)	ur	ık
	e P	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Maili	ng Address	S (Street a	and Number	or Rural Route Nu	umber, City	or Town, S	tate, Zip Code)	
MD d 2 sho lth and n 27 is numati		O.C.M.E.			1.0				ltimore,		21201	, , , , , , , , , , , , , , , , , , , ,	
re, ME s 1 and 2 s of Health a If item 27	-[20a. Method of Disposition 1 Burial 2 Cremation 3] D		Place of Disponentary or o			etery,	Date	20c. Lo	cation - City	or Town, State	
MOF Pages bent of unt: If		4 Donation 5 X Other Specify:	in state	۲	Siciliatory of C	Arier place,	,						
Baltimore, permit Pages 1 a Department of He Important: If ite injury or other ti	- 1	21. Signal - of Funeral Service License Ronald So W	e // /		22.	Name and	Address o	f Facility	rd 655 W	Ba.	ltimor	e Street	
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Physician /Medical	1	23a. Part I. Enter the disease, of complic ailure. List only one cause on each	ations that caused to tline.	ne death.	Do not enter	the mode	of dying, si	ich as cardia	c or respiratory a	rrest, shoc	k, or heart	Approximate Inte Between Onset	
taminer	İ	Imme the Cause (Final disease a. I or condition resulting in death)	hypertensive	e athe	eroscler	otic c	ardiov	ascular	disease a	sociat	ed with	1 reg Death	
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Box 68760, e death certificate by the attending physic of for use as the bur	8	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregr	nancy	0,00 1				23d.	Date of deli	very	
certif	Sian	past 12 months?	1 Live birth 4 Pregnant at ti	me of dea	ath -	etal death	3 _	Ectopic preg	gnancy	N	/ionth	Day Year	
BOX death	Š	1 Yes 2 No 9 Unknown	9 Unknown		5 C	ther (Spec	ciry)						
P.O. ss that the gned by t	by Phy	Part II. Other significant conditions	ontributing to death	but not re	esulting in the	underlying	cause give	en in Part I.	23e. Did	tobacco us	se contribute	to the cause of death?	
S, P.C			<u>.</u>						_ 1 _ Ye	es 2	No 3 F	Probably 4 🗹 Unknow	VN
cords law requir	Completed								24a. Was			autopsy findings availate completion of cause	
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n of ding Pl After funera	ij۱	27. Manner of Death 1 X Natural 5 Panding	28a. Date of Injury (Month, Day, Yea	r)	28b. Time of	Injury 2	28c. Injury a		28d. Describe	how injur	y occurred		
IVISIOR or Attend after death. Director: in by the	<u> </u>	2 Accident Pending Investigation	00 - 51 - 11					2 No					
Division of Vital Records, spital or Attending Physician: The law requinours after death. teral Director: After this certificate has been si filled in by the funeral director, page 2 should the control of the contro	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At no	me, tarm, stre	et, factory	, office buil	ding, etc.	or Town,		d Number or	Rural Route Number, (City
Hospid 4 hour Funers		4 Homicide 29a. Certifier 1 Certifying Physician	1	coowledg	e death occu	urred at the	time date	and place of	nd due to the equ	100/0) 074		National Control	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici or page 1 should be detached for use as the burity of the former of the for	Medical	one) 2 Medical Examiner: 0	n the basis of exami										
FFF8	Me	29b. Signature and title of certifier	nd manner stated.			290	. License n	umber		29d. Da	ate signed (Month, Day, Year)	
		Theodore MI	1. K. 1.	ועד	4. 0		O.C.M.	E.	DOME	Nove	mber 15,	2007	
		30. Name and address of person who con											
		Theodore M. King, Jr., MD.	Assistant Me			111 Pe	nn Stree	et, Baltimo	ore, MD 2120	1			
Stat Registra		31. Date filed (Month, Day, Year) NOV 2 9 2007	32 Registrar's	Signatur	re	B. a							
		1100 - 0 1.001	90 6 9 8 3 3	18.90	S. 65 16 6	24.4							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 Per State of Maryland & Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day **Physician** 11:06 PM HIGHNS November 26 2007 exIME /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TODKINS 8. Date of Birth (Month, Day, Year) 2-25-1933 24 Hrs. 9. Birthplace (State or Foreign rs. last birthday 212-30-6788 **Funeral** Months Hours Min 1 □ M 2 🗓 F MARYLAND 74 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State show r 28a-f show notified at 1X Yes 2 □ No Funeral Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 21218 USA 1413 HOMESTEAD ST. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: BLACK 2 3 Widowed 4 Divorced Completed permit, Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumattc event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BOWMAN MONROE JOSEPHINE WILLIAMS ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1413 HOMESTEAD ST. BALTIMRE MARYLAND 21218 ROBERT WILLIAMS (HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ remation 4 □ Donation 5 □ Other 3 Removal from State KING MEMORIAL PARK 12-4-2007 BALTIMORE, MARYLAND 6 ☐ Other (Specify) HIBNER. Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of Funeral Service Ligensee JONATHAN 1721-27 N. MONROE ST, BALTIMORE, MARYLAND 21217 23a. Part / Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ause (Final Immedia ardio **Physician** MINUTE pulmonany disease of condition resulting in death) /Medical Tue to (or as a consequence of): Examiner Heant if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit ungestive Due tector as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year 5 ☐ Other (specify) 4 □ Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Inknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No 1□ Yes To the Hospital or Attending Physician: ours after death.

Ieral Director: After this certification in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066048 , may NOVEMBER 27, 2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 600 NORTH WOLFE BALTIMONE MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23 Pay Nov. 2007 **Physician** 12:52 AM Sidney Vincent Walker /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Clinton, Maryland Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1**√** M 2□ F Days 02/02/1936 71 577-44-6375 Director Washington, D C Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10h County 1√1 Yes 2 No Director P G Hyattsville, Maryland MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5705 37th Ave items 23a USA "natural", or items 23a 20782 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√ Yes 2 □ No If Yes, Give Year or Dates:55 - 65 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **Black** þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and 2 should be filed within eatth and Mental Hygiene. <u>Telephone Tecnician</u> Verzion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Harris George Walker Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau 2665 MLK Ave. S. E. Washington, D C 20020 Barbara Walker (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 30, 2007 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Lices 3821 14th Street N W Washington, D C 20011 Terry A Austin 23a. Part1. Enter the discase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the aftending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Vear in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 DUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ HYPERTENSION 1 Tyes 2 No 3 Probably 4 Unknown Completed HEART FAILURE CONGESTIVE Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 performe 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? ne Hospital or Attending Pont 24 hours after death. After t Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated

Registra

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29b. Signature and title of certifie

TODEIC

TERRY JODRIE, M.D.

31. Date filed (Month, Day, Year) NOV 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D40324

7503 SURRATTS ROAD, CLINTON, MARYLAND

29d. Date signed (Month, Day, Year)

NOVEMBER 23, 2007

			For State of Marylai 1 - State Registrar	nd / Depa			Mental Hy	giene	007	38189
			Decedent's Name (First, Middle, Last)		timodio or	D04.77	2. Date of De	Reg. No	-	3. Time of Death
	Physic		Michael Yim				Month	Day	Year	
	/Medi		4a. Facility Name (If not institution, give street and number)		4h City Town	or Location of Death	NOV	25 40 CC	2007 Junty of Death	7:15 A M
	Exami	ner		~~~		AIR			ARFOR	D
				LAST DIRTHORY			8 Date of Bird			
	Funeral Director		218-76-7714 1\(\frac{1}{3}\)M 2□ F 7		Months Days		8. Date of Bird (Month, Da 09-09-1	y, Year)	Japan	place (State or Foreign ntry)
			Usual Residence of Decedent	J			07-07-1	734	Japa	
	yland 10w			ity, Town or Lo	cation					10d. Inside City Limits
	Mar	to	Maryland Harford	Bel A	Air					1 ☐ Yes 2 No
	ours after death with the Marylar rel', or Iteme 23a or 28e-1 ehow Exemitier misst be notified at	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	h wit	<u>E</u>	1710 Stone Ridge Ct		2101	5		U.S.	Α.	
	deat me.	ner	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. V		Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No		Race - Ameri	
9	or Ite	F	Armed Forces? 1 ☐ Never Married 2 🗓 Married 1 ☐ Yes 2 🗓 No				Hican, etc.)		Black, White,	etc.
93	ours Frai.	i by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1□Yes 2🌠 No	Specify:		Sp	ecity:	ain
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7	ug e	du	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retire	od)				
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<u>p</u>	be fill tat H d out	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Su	mame)	
× a	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene is marked other then "natural", or Iteme 23a or 28a-1 ehow aumatic event, the Madical Examitear must be notified at	ို	Kyungkia Yim			Samboong				
Maryland 21215-0036	0.00		19a. Informant's Name/Relationship (Type, Print) Mihee Kim (Daughter)			and Number or Rur		-		Code)
	Health tem 27		,,			idge Ct Be				
0.0	Pages 1 nent of H int: If Ite		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	sition (Name of natory or other pla	109)	Date	20c. Locat	tion - City or To	own, State
Baltimore,			4 □Donation 5 □Other (Specify) Be	1 Air Me	emorial (Sar. 11-29	2007	Bel A	ir, Maı	cyland
3ali	permit. Departr Imports eny Inju		21. Signature of Funeral Service Licensee	22	. Name and Addr	ess of Facility Sch	imunek	Funera	al Home	of Bel Air
	7029		uddel.			V. MacPhai	1 Rd Be	1 Air		
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ente	er the mode of dy	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1	Dinen	10				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consec	quence of):	11	100				
	LAGITIMICI	_	Sequentially list conditions. U. Facture	V + 8	Thriv	9				
14/	/p #	Examiner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	quence of):						
4	and I-tran	кап	cause (Disease of Injury that initiated events resulting in death) Last C. Due to (or as a consec	augus of						
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m	physic the	dlcai	d				······			
×	death certificat a attending phy od for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregn	20.04						
€ g	atten for u	lan	in the past 12 months?	aldeath 3□	Ectopic pregnanc	у		23d	 Date of deliver Month 	ery Day Year
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> a	that the ded by the detached	유	Part II. Other significant conditions contributing to death but not res	sulting in the up	nderlying cause gr	ven in Part I	23e Did to	hacco use	contribute to t	he cause of death?
d.	sign d be	d by	Dispotes Mellitu	ct	100 T		1 🗆 Y			pably 4 □Unknown
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HAEL Vital Record	e la has je 2	Completed	Kenal tarrive				24a. Was autop		24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
m m	ician: The centificete ha						1 ☐ Yes	2 NO	1 ☐ Yes	21,00
HH Vita		Be	25. Was case referred to redical examiner?		Ott	26. Place of Death				
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\ 1 =	ding Phi h. After thi funeral	퉏	1 □Natural 5 □ Pending (Month, Day Year)	Injury	28c. Inju Wo	rk? Yes 2 □ No	200. 176501061	low inquiry or	ccurred	
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S	after Dire	Certification;	4 Homicide determined 28e. Place of Injury - At h	fy)	out, ractory, office		City or Tou		5///20/ O/ 11g/	ar roote ramber,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier	owledge, death	occurred at the II	me, date and place	and due to the	cause(s) and	d manner as s	tated
	• Ho • Fu • Fu letely	Medical	(Check only 2 Medical Examiner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my	opinion, death occurr	ed at the time,	date and pla	ice, and due to	the cause(s)
_	To th To th	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date s	igned (Month,	Day, Year)
	0		Y Man / MM	_wo	1	CTV2		Va. L	in hou	75 200
	2		30. Name and address of person who completed cause of teath (Iter	m 23a) (Tyne 1	Print) ~-	1714 3		11	MUCH	43, 2001
	Ø		Manuel Lazati nD	, (.,),	P	Law Sti	reel	Abel	rdeRi	2, Marylan
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	Registr	ar	NOV 2 9 2007	the state of	rockes					

		For State Registrar		nd / Department of H Certificate of L	Death	Reg. N		38190
Physicia /Medic	in al	1. Decedent's Name (First, Middle, Las Zawd	itu Yacob		L	Ovembe	y Year	3. Time of Death
Examine	*'	4a. Facility Name (If not institution, give	1 of Balti	nor Baltin		Date of Birth	c. County of Death	A place (State or Fore
Funeral Director		227-73-6619 ¹ Usual Residence of Decedent	□ M 212 F	70 Yrs. Months Days	Hours Min.	Month, Day, Year	37 Cou	Hiopia
h the Marylan r 28e-f show	ctor	Maryland 10b. County) 10c. Ci		timore			1 TV es 2 1
s 23a or 2	Funeral Director		+ Ave.	10f. Zip Code	October 100		itizen of What Cou	4
030 urs a	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Orvorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of Hi If Yes, specify Cubai 1 Yes 2 No	Ispanic Origin? (Specily, Mexican, Puerto Ric	an, etc.)	Black, White,	
21215-000: Id within 72 hours giene. Pr then "neturel", Inter Medical Ext	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	during most of working		inisty of	f Health
be be	To Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name (F UNKnown		n Sumame)	
C = 44 F		19a. Informant's Name/Relationship (1) Manna Gima-	Griend	19b. Mailing Address (Street a		oute Number, City MHLic	alts, Mai	yland
2 3 4 2 2		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify	Removal from State	Place of Disposition (Name of cometery, crematory or other place + Lincoln Cer	m. 1241/6	7 Br	Location - City or T	Swn, State Maryle
Baltimo permit. Pag Department Importent: I any injury o		21. Signature of Funeral Solvice Licen	Parker	22. Name and Address 3572 Free	device A	re. Batt	imore M	2.3122
Physician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deal one cause on each line. a	Shock	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
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rds, P puires that n signed b	d by Pl	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to 2 No 3 ☐ Pro	the cause of death bably 4 □Unkn
Il Record The law require ate has been si	omplete	Hyperhoiden	nia			24a. Was an autopsy performed?	death?	opsy findings avail ompletion of cause
of Vital F hysicien: Th his certificate al director, pag	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 No		ER/Outpatient 3 DOA Othe	4 I ladi sing 1 lonte	5 🗆 Residence		fy)
Division of Vital Records, to the Hospitel or Attending Physicien: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be completely filled in by the funeral director.	Certification;	27. Manner of Death 1 1 2 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28b. Time of Injury Work M 28c. Injury Work 1 1 1	k? Yes 2 □ No	d. Describe how inj Location (Street a City or Town, Sta	and Number or Rui	al Route Number,
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To the I within 2 To the Complet	Me	29b. Signature and tille of certifier	s O yoge	29c, License D 5	4931 5917AL		oate signed (Month	
		30. Name and address of person who	completed squad of death (to	m 23a) (Type, Print)				-

ımanuel K. As	1	- For State	ate of Ma	aryland /	Depar / Cert	rtment of hificate of	Health Death	and	Menta	l Hygie		j, No	200	7	3819
Physicia	n/	teqistrar 1. Decedent's Name (First, Middl	e,Last)							l Mc	te of Death	Dav	Year		of Death 0 hrs
edical Examir		EMMANU		K.	ASAN'		b. City, To	wn orlo	ocation of F		tober 28		ounty of Death		01113
		4a. Facility Name (if not institutio N495/95 Outerloop	i, give street a	and number)		.	College						ce George		
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. la	st birthday)	If Under	_	If Under 2		Date of Birth	(MM/DD/	YYYY) 9. Bir	thplace (State or UNK .
Director		105-86-4195 THE	1 X M 2	_	32	Yrs.	Months	Days	Hours	Min.	w. 16,		Co		Ghana
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vith the Maryland s 23a or 28a-f show any e notified at once.	함	MD. Montg	DIETY		_ Bet	hesda UNK.	10f. Zip C	Code			INIZ 10	g. Citizen	of What Cou	intry?	
he Ma or 28	Director	8901 Wisconsin	Ave. #C	2061		UNK:	2088	3 9		7	INIC		U.S.A	١.	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 13a or 28a-f she natic event, the Medical Examiner must be notified at once		11. Marital Status UNK	12. Wa	as Decedent			s Deceden	t of Hispa		? (Specify Puerto Ricar		14.	Race - Ame White, etc.		an, Black,
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2 hour	ited	Elementary/Secondary (0-12)	Col	llege (1-4 or		during mo	ost of work	ing life. [OO NOT us	se retired)					
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5-0 iled w Hygie I othe		17. Father's Name (First, Middle	, Last)				-UNK	- 18	8.Mother's	Name (Firs	t, Middle, N	laiden Su	rname)		-UNK
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 77 is marked other than "natural", natic event, the Medical Examiner.	o Be	Mensah Asante 19a, Informant's Name/Relations	ship (Type, Pri	nt)	UNK.	19b. Mailing	Address	(Street	Abena and Numb	er or Rural	Route Num	ber, City	or Town, Stat	e, Zip Co	ode) UNK
Tore, MD 21215-0036 gges I and 2 should be filed within 72 hours after death wit of Health and Mental Hygiene tt: If item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be	F	Pokuaa Adwoa/		,	UNIX	P.O. E						na			
e, M 1 and 2 Health Fitem 2	ŀ	20a. Method of Disposition		-UNK		Place of Dispos crematory or oth	ition (Nam	e of cem	etery,	Da	te UNK	20c. Loc	cation - City o		State
MOF Pages ent of nt: 1f		1 XBurial 2 Cremation 4 Donation 5 Other S		noval from S		yland Ve				Jan 18,	2008	Crow	nsville	, MD.	101, 110.
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr	İ	21. Signature of Funeral Service		10		²² CF	AMBE	Address i	Ú ŘEĽYA	L HOM	IE & C	REMA	TORIUM	, P. A	7.
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cax 6876(eath certificate attending phy. for use as the b	sician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		Live birth		2 F6	etal death	3	Ectopic	pregnancy		N	Month	Day	Year
Box 6 e death cer the attendi ed for use	sicis		nknown g	Pregnant a	at time of de	eath 5 O	ther (Spec	cify)				1			
O. B. trthe de by the ached f	Phy	Part II. Other significant cond			ath but not r	esulting in the	underlying	cause g	iven in Par	rt 1.	23e. Did t	obacco us	se contribute	to the ca	use of death?
P.O ires that to signed by I be detac	by										1 Ye	s 2 🗸	No 3 P	robably	4 Unknown
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Division tal or Attendi 13 after death. 14 Director: /	Certification:		estigation C	Oct 28, 200	7	0059 hrs	eet factory				f. Location	Street an	d Number or	Rural Ro	oute Number, City
Divis	rtifi	det	uld not be	Specify) L			oc, 100to y	, 011100 0	and g, on				College Par		
Lospit 4 hour Funer; ely fill		4 Homicide 29a. Certifier 1 Certifying	Physician: To	the hest of	my knowled	de death occu	urred at the	time, da	ate and pla	ice, and due	e to the cau	se(s) and	manner as s	tated.	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only one) 2 Medical Ex	aminer:On the	e basis of ex	camination a	and/or investiga	ation, in my	opinion	, death occ	curred at th	e time, date	and plac	ce, and due to	the cau	
P ≥ F S	Me	29b. Signature and title of certif					290		e number			1	bor 28 20		ay, Year)
		mer						O.C.I	IVI. ∟ .			UCIO	ber 28, 20		
(σ_i)		30. Name and address of person Ana Rubio MD. As	on who comple ssistant Me			^{n 23a)} 111 Penn	Street F	Baltimo	ore. MD	21201					
	tate				rar's Signat	hure .									
S Regis				1000	A	Cooce	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#4a.PerPhys.PCC11-7-07cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** асоь Rank OCT. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bowie Health Center INCE Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 M 2 □ F 18-9426 Director 1919 Fincastle Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director COVE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 Nocala 1.Ve Funeral 12. Was Decedent Ever in U.S. Armed Forces? 152Yes 2 □ No NQUY 17Yes, Give Year or Dates: \ QUU - | QUU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 4 40 Specify: < Black ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) DUT Equipment Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Landover HD 20184 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Poplar Eaphist Nov. 3, 2007 Wingston 21. Signature of Funeral Service License 22. Name and Address of Facility Funaral Juawana 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9013 20706 Immediate Cause (Final disease or condition resulting in death) **Physician** cudiomycpathy /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760, physician Physician/Medical the the attending phone IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page certificate 2 🗆 No 1∐ Yes 2° No 1 ☐ Yes Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA P After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Vovember 30 am David Beiber 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctor's Lanham Prince George's Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 17, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Texas 1 XM 2 ☐ F Months 089-12-9906 Director 83 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits a or 28a-f show t be notified at 28a-f show 1 □Yes 2 □ No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20720 USA 6601 Fannon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Tavid Delease Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify: \$ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer NASA Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Greenberg Max Beiber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Jacobs / daughter 6601 Fannon Drive Bowie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 11/06/2007 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses Bowie, MD. 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner UADRINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed CERVICA Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richam 9500 31. Date filed (Month, Day, NIOV 0 7 200 32. Registrar's Signature State Registrar

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36	be filed within 72 hours atter death with the Maryland ttal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ♣ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decede If Yes, specif 1 □ Yes 2	nt of Hispanic Origi y Cuban, Mexican, ☑ No Specify:	in? (Specify Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
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	1		Deepnarayan Tiwarı	ri, MD 7525	Greenw		nter Driv	e, Gr	eenbelt	, MD 2077	70
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** November 9, Corynne Berkowitz 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 126-22-5085 Yrs Director April 14, 1931 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medk-11 Ex milner must be notified at MD 1 XYes 2 No Montgomery Rockville Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14427 Barkwood Drive 20853 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White þ 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 Is marked other the any injury or other traumatic event, the Jonce. Court Reporter Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Morris Moskowitz Lillian Richer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Nevins - Daughter 8018 Summer Mill Court Bethesda MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 11/11/07 Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Birection IBc 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MMa disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe Very the Hospiter within 24 hours after death. To the Funeral Director: After this certificate armietely filled in by the funeral director, par 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2X No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

31. Date filed (Month, Day, Year)

NOV 14 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

November

Berkowitz, Corynne

Gabriel Peter Pushkas 11510 Old Georgetown Road Rockville MD 20852

Registrar's Signature

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08983 State of Maryland / Department of Health and Mental Hygiene James E. Boone, Sr. Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1526 hrs November 20, 2007 Medical Examiner James Ε. Boone, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll Taneytown 21 E. Baltimore Street Apt. 5 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) 5. Social Security Number Foreign **Funeral** Min. Days Hours Months Country Maryland Director July 24, Yrs 1 X M 2 F 57 219-54-1088 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Taneytown Carrol1 Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United<u>States</u> ā 21787 Street 21 E. Baltimore 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married Married 1 X Yes Specify: White Yes 2 X No specify: If Yes, Give Year Divorced 3 X Widowed ۵ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) permit. Pages I and 2 should be filed within 72 hours i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Heavy Equipment Operator 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Pauline V.</u> Unknown Be Harold Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21702 Frederick, 930 Taney Avenue James E. Boone, Jr. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 November Removal from State 24, 2007 Frederick, Maryland Stauffer Crematory Donation 5 Other Specify: 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licensee Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical Alprazolam intoxication Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): iner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Exami Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical physician a the burial -X UNPENDED perME.2874. 12/11/07 TT .28a-f 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed by the director, page 2 should be detached Ö 1 Yes 2 No 3 Probably 4 ✔ Unknown \$ Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other: Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: ER/Outpatient 3 2 Inpatient this 1 V Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 27. Manner of Death Certification: Yes 2 X No Natural subject ingested pills 5 Pending Fnd 11/20/2007 Fnd 3:13 pm Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 2 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 XX Suicide Baltimore St. Taneytown, MD (Specify) Homicide House Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 • Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Many Day 2 eac)

30. Name and address of person who completed cause of death (Item 23a)

2007

Assistant Medical Examiner

32/Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 21, 2007

amend item 17 per fcPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 11/07/07 dlState of Maryland / Department of Health and Mental Hygiene 2 0 7 1 = State amend line 10e per, fd Registraracco hith dept 11/13/07 dlw Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 11/5/2007 8:55pm 1anne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 3865 Wayson Rd. Davidsonville Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Manth 2011 1912 1 □ M 2030 F 113-09-0429 94 Netherlands Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County canonicated Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show is marked other than Medical Examiner must be notified at MD Davidsonville Anne Arundel 1 ☐ Yes ŽŽNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3865 Wayson Rd. 3856 Wayson Rd. 21035 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Realtor/Owner Realestate Johanne A.L. Vander Bosch 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi tealth and Mental F Barones Ernestine Van Hardenbrock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Davidsonville, MD 21035 Hal Clagett 3865 Wayson Rd. Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Metro Crematory 11/7/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of): Examiner The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ed by the attending detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal dea
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) ☐ Yes 2 No 9 ☐ Unknown been signed I should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1□ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: A d in by the fu 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral I completely filled 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) of ce 0 30. Name and address of person who leted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State **HQV 0 7 2007** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) October 29, 2007 Jessie Ruth Smith Craighead 3:45 A. M 4c. County of Death Facility Name (If not institution, give street and number) St. Thomas More Nursing and 4b. City, Town, or Location of Death **Prince Georges** Hyattsville Rehabilitation Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 10 , 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Months 1 M 2 X F 77 1930 North Carolina 246-36-8885 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Y Yes 2 □ No Hyattsville Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20782 4922 LaSalle Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married **Black** 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Domestic Worker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phebia Whitley Griffin Don 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 Sultan Avenue; Capitol Heights, Maryland 20743 Maxine Holmes (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 1, 2007 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 21. Signature of Fureral Service Li R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N. W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Immediate Cause (Final disease or condition resulting in death) ruckovasa 1 lews Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an was autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a Examiner must

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'natural"

marked other

Department of Health and Mental Important: If Item 27 is marked o any injury or other traumatic eve once.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

be notified

Directo

Funeral

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Completed

Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760

Examiner Physician/Medical þ Completed Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FFMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) PRE MAS

32. Registrar's Sign

Registrar

Queensbury Rd Hyatts sille and 20781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician verember 3 200) CALVIN LEONARD LORENZO CHASE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Murikink Lans eour 5 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Days Hours 1 XX M 2 □ F MARYLAND 220-62-5090 JUNE 29 1954 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State show r 28a-f show notified at tv Yes 2 No Director PRINCE GEORGE'S LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 9508 MUIRKIRK ROAD # 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No BLACK Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th ANALYST DOCUMENT PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be file f Health and Mental H tem 27 is marked oth Be LAWRENCE **EDWARD** CHASE VIRGINIA QUEEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) : If item 27 i TRITINA JOHNSON/DAUGHTER 7904 CANDLEWOOD PLACE GREENBELT, MARYLAND 20770 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 11/6/2007 Important: I any injury o RIVERDALE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arteriosc **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical F FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ thknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 28 No 1 ☐ Yes 1∏ Yes 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide determined within 24 hours a To the Funeral L 1 Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760.

Division or Vital Records, P.O.

State

31. Date filed (Month, Day, Year)

30. Name and address of person who empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 6^{4y} , 200^{4y} 1:45 P M Selma B. Clair November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis Spa Creek Center if Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 ₩ F 84 Pennsylvania 4/24/1923 187-16-8151 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural"; or Items 23a are 200. Constitution of the traumatic access. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland Annapolis Director Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2542 Mission Hills Ct. 21401 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Engineering Services Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Sarah (unknown) Samuel Blackman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1213 Independence Ave., S.E., Washington, D.C.20003 Jeffrey A. Clair/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/8/07 Kalas Crematory Edgewater, MD 4 □ Donation 5 □ Other (Specify) 21. Signat of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home hito 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final س ک **Physician** 5 C resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be execute burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔭 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident To the Hospital or Attency within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and til

State

Registrar

30 Name and address of person who completed cause of death (Itam 23a) (Type, Print) 11em 23a) (Type, Print) D- we Cherler, MD 2/6/9 31. Date filed (Month, Day,

32 Registrar's Signature NOV 0 9 2007

32036

07-08782 Christian Cruz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hristian Cruz		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.											
Physician ledical Examine	1/	Decedent's Name (First, Middle,Last) Christian Cruz	2. Date of Deat Month November		3. Time of Death 0216 hrs								
	4	Bonifont Road & Alderton Road 4b. City, Town, or Location of Deal Silver Spring		4c. County of Death Montgomery									
Funeral Director	,	5. Social Security Number 220-29-8130 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24HI Months Days Hours Mi		th(MM/DD/YYYY) 9. Bir Foreig Co	thplace (State or in untry) MD •								
Maryland 28a-f show any d at once.		Journal Residence of Decedent 10a. State Montgomery 10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 Yes 2 No								
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	106. Street and Number 621 Beacon Road #F 20903	10	og. Citizen of What Cou	ntry?								
r death	by Funeral	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	to Rican, etc.) Llvadore	White, etc. Specify:	White								
5-0036 led within 72 hours afte Hygiene. the Medical Examiner	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 1	etired)	Highsch									
21215-0036 ould be filed within 7 Mental Hygiene. I marked other than ie event, the Medica	Be Co	Jose Hector Cruz Ana M	me (First, Middle, I Iaria Go	onzalez									
MD 21 2 should h and Me 27 is ma	٤	19a. Informant's Name/Relationship (Type, Print) Jose Hector Cruz/Father 19b. Mailing Address (Street and Number of the Company of the Comp		Spring,N	1d.20903								
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Memal J Important: If item 27 is marked injury or other fraumatic event,		4 Donation 5 Other Specify:	Date /16/07		lle,Md.								
Balti permit. Departn Imports injury o		21. Sign tre of Funeral Service Licensy PHILIP D.RINALD 9241 Columbia B	RAL SERVIC	CE,P.A. ng,Md20910									
Physician /Medical xaminer	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death								
Xammer		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.											
0	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated											
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760, cate be ex physician	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver									
Box 6876(death certificate he attending phyud for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant 12 months? 1 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	gnancy	Month	Day Year								
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Vital Rec ysician: The I his certificate I director, page	&	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nur	rsing Home 5	Residence 6 🗸 Othe	er: Scene								
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Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	Suicide 6 Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined	(Street and Number or R State) Alderton Rds., Whea	tural Route Number, City aton, MD									
To the Hosp within 24 hd To the Fun completely:	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a cone of the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control occurred at the control	se(s) and manner as sta e and place, and due to t	ated. the cause(s)									
To To con	Me	and manner stated. 29c. License number O.C.M.E.	29d. Date signed (M November 12, 2										
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201										
Sta Regist	ate	31. Date filed (Inch Pay Year 2007 32 egistrar's Signature											

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Brian F. Duggan NOVEMBER 4,2007 8:04 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LA PLATA CHARLES CENTER CIVISTA MEDICAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) May 1, 1964 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Mir 1 □ M 2 🕅 F 218-86-0854 Yrs 43 Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No Director Maryland | Prince George Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be re 15601 Main Blvd. USA 20607 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Restaurant 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John M. Duggan Catherine F. Sullivan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Duggan/Sister 8812 Battery Rd. Alexandria, VA. 22308 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11/5/2007 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature uneral Service Licens a 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HSCIFES **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2€No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings av₃ilable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1□ Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 **Inpatient** 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Directory filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely To the within 2 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52289 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11855 HOLL LANE SUITE 107 WALDORF, MD MATHUR. 31. Date filed (Month, Day, Year) State NOV 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U / 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month .Dav **Physician** Frederick Oliver Drew Nevember 7007 0908 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner linten Mas Hospi If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 577-48-6263 70 Director Dec. 9, 1936 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Marvland Prince George Director Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 USA 7002 Independence St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1956-If Yes, Give Year or Dates: 1958 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 12 should be filed within 72 hours after on and Mental Hygiene.
is marked other than "natural", or ite 2□No 1956-1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Black Completed by 3 ☐ Widowed 4 🎇 Divorced 1958 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer US Printing Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie E. Drew SAdie Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun once. Marjorie Weaver/Sister 7002 Independence St. Capitol Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State Maryland Vet. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/8/2007 Cheltenham, Maryland 22. Name and Address of Facility orge F. Kalas Funeral Home 21. Signature 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Com disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 donknown cate has been signated by page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

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			1 State	State of Mary		artment of H		nd Mental Hy	-201	17 31	8205
			Registrar 1. Decedent's Name (First, Middle, Last)			Timeate of t	Deatri	2. Date of De	Reg. No.C., U (ime of Death
	Physici		•	nomas Dixo	n			Month Novemb	er 7, 20	Year 007 1 • 1	10 AM ^M
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	r Location of		4c. County		10 1111
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	Funeral				yrs. last birthday)	If Under 1 Year	If Under 2		th v Vear)	9. Birthplace (Si Country)	tate or Foreign
в	Director		577-38-8641	^{4 2□ F} 70	б Yrs.	Months Days	Hours	Min. (Month, Pa	930	Washing	
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	arylar show	ايا	10a. State 10b. County	100	c. City, Town or Lo	ocation					Yes 2 No
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	Itam Itam	Į,	11. Marital Status 1 ☐ Never Ma <i>rried</i> 2 💥 Married	Armed Forces? 1 X Yes 2 □ No	in 0.5.	If Yes, specify Cuba	in, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Black	k, White, etc.	
36	irs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 19	49-53	1□Yes 2XX No	Specify:		Specity:	White	
ŏ	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or Itame 23e or 28e-f show event, The Medical Esafr har must be notified at		15. Decedent's Educa	tion	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu	siness/Industry	
212	within 7. ene. than "n	ple	(Specify only highest grade and Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most d)	of working			
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P	be filed ital Hygi od other event, I	Be C	17. Father's Name (First, Middle, Last)					's Name (First, Middle	, Ma <i>id</i> en Su <i>ma</i> mi	θ)	
<u>a</u>	Mental Mental arked c	70	Har	ry Thomas 1	Dixon, S	r.	Rut	h Young			
Maryland 21215-0036	2 should be and Mental is marked is umatic ev		19a. Informant's Name/Relationship (Type					or Rural Route Numb			,
≥ ′	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked sny injury or other traumatic e once.		Dolores J. Dixon/ N	Ct., Annar							
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei	- 1		matory or other plac		Date		City or Town, Sta	
Ë	Pag Imenitant: Jury		' 4 ☐ Donation 5 ☐ Other (Specify)			Cremator	-	1/9/07		ater, MD	
3all	Deparition Department Importment		21. Signature of Funeral Service Licensee	1.				George P.			
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8760,	Physician /Medical Examiner parial-transit	I Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):	hc M	Dersh	uall Ce	el Con	nce Priset	t and Death
P.O. Box 687	t the death certificate by the attending phy: ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		Mor		Year
	50 00	by	Part II. Other significant conditions contri	ibuting to death but no	ot resulting in the u	inderlying cause give	en in Part I.		tobacco use contr		_
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7	Hospitel 24 hours Funerel stely filled	edical Ce	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of m er: On the basis of exa and manner stated.	amination and/or in	th occurred at the tin	ne, date and pinion, deat	place, and due to the h occurred at the time	cause(s) and ma , date and place, a	nner as stated. and due to the ca	ause(s)
	To the within 2 To the complete	Med	29b. Signature and title of certifier	and mainer stated.	•	29c. Licensi	e number		29d. Date signed	1 (Month, Day, Y	'ear)
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	WXA	1	30. Name and address of person who com	poleted cause of death	(Item 23a) (Tune	Print)	(90)0	510 m	1600	ALIN	3/
	COT"	Y	Undi k	20 18	Dela	Sw ?	700	30 BIL	40707	£ 21	2047
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	Registi	rar	NOV 0 9 20	UI AMORELA		STATE OF THE PARTY				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 6:45 2007 Robert Raymond DeSimone November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice - Casey House Montgomery Rockville 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F Min. 78 Director 578-42-4854 August 15, 1929 District of Columbia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18821 Rolling Acres Way 20832 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ⊠Yes 2□No If Yes, Give Year or Dates: Korean War 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify. Specify. Completed by White 3 Widowed 4 Divorced "natural" traumatic event, the Medical Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tat Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OTIS Elevator Elevator Technician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Menta 2 Ralph DeSimone Rosa Teresa DiMenra 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Patricia L. DeSimone - Spouse 18821 Rolling Acres Way, Olney, Maryland 20832 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 11/15/2007 Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) Cancer of Unknown Primary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 1⊟ Yes 2 K No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 COther (Specify) Hospital: 1 ☐ Yes 2X No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred **Hospital or Attending** 1 X Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 😕 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) ို my D0064615 November 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 1 4 2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O.

Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death November 10, 2007 DeWitt E. DeLawter 6:25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 8. Date of Birth (Month, Day, Yea May 18, 1 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign
Country) 1**∑**M 2□F 91 1916 Maryland 213-38-1089 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 368 Russell Ave. 20877 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 SYes 2 No1942 to Yes, Give Year or Dates: 1946 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 5+ 18. Mother's Name (First, Middle, Maiden Surname) Bertha Brandenburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9729 Whetstone Dr. Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12, Metropolitan Crem. Alexandria, Va. 2007 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877

Day

29d. Date signed (Month, Day, Year) November 11, 2007

Year

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other it any Injury or other traumatic event, the Once. **Physician** /Medical **Examiner**

Physician

/Medical

Examiner

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within 72 hours after death

3altimore, Maryland 21215-0036

certificate be executed

Box 68760,

P.O.

Records,

Division or Vital

Physician:

or Attending

Examine burial-transi and physician s the burial Physician/Medical as attending use signed by the a þ Completed een page funeral director, Be ဥ Certification: To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu

Completed 17, Father's Name (First, Middle, Last) Be Otho Victor DeLawter ပ 19a. Informant's Name/Relationship (Type. Print) Dorothy Jones (Daughter) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License urtin 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Artery Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause Unsease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Urinary Tract Infection 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1☐ Yes 2 💢 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nor stated

Registrar

State

29b. Signature and title of gertifier

31. Date filed (Month, Day, Year)

201 Russell Ave. Gaithersburg, Md. 20877 32 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ndidi Bonique Feinberg M.D.

NOV 1 4 2007

29c. License number

D0059423

Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician:

filled in by

State Registrar ATTENDING PHYSICIAN 29c. License number DO057216

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3450 Fort Meade Rd # 209 Laurel Maryland 20724 Michael N. Baako M.D.

29b. Signature and title of certifier

29a. Certifier

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Medical

and manner stated.

			For 1 _ State	S	tate of Man	yland / [Mental Hy	giene	0.05		
			Registrar 1. Decedent's Name (First, M	fiddle (act)			Certific	ate of De	eath	O Date of D	Reg. No.	00/	382	09
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	/Medic Examin		ANN ROE 4a. Facility Name (If not instit		et and number)		4b. C	ity, Town, or Lo	cation of Dea	NOVEMBE	1	2007 unty of Death	2:45P	М. ""
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4	Funeral		5. Social Security Number	6. Sex 1 ☐ M	21 V E	n yrs. last bir	Mont		Under 24 Hrs Hours Min	. (Month, Da	th ay, Year)	9. Birthp	place (State or	Foreign
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Divo	Married	Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	If Yes,	specify Cuban, f	anic Origin? (Mexican, Pue S <i>pecify:</i>	Specify Yes or Norto Rican, etc.)		Race - Americ Black, White, pecify: WHI	etc.	
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	that the ed by detac	P.	Part II. Other significant cor	nditions contrib	uting to death but n	not resulting in	n the underlyi	ng cause given is	in Part I.	23e. Did	tobacco use	contribute to t	he cause of de	eath?
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Division or Vital	ding Physician: The n. After this certificate ha funeral director, page	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pe	ending	28a. Date of Injury (Month, Day Y		Time of Injury	28c. Injury at Work?		28d. Describe	how injury o	ccurred		
<u>S</u>	or Attencatter death Director;	icat	3 ☐ Suicide 6 ☐ Co	vestigation ould not be	28e. Place of injury	- At home, fa	M irm. street, fai		s 2□No	28f. Location	Street and N	lumber or Rus	al Route Numi	har
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	edical C	29a. Certifier 1 Cert (Check only one) 2 Med	ifying Physicia lical Examiner:	an: To the best of n : On the basis of ex and manner stated	camination ar	e, death occur nd/or investiga	red at the time, tion, in my opini	date and place ion, death occ	ce, and due to the curred at the time	cause(s) ar , date and pl	nd manner as s ace, and due t	stated. o the cause(s))
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	nt		30. Name and address of pe	son who compl										
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DHMH 17 Rev 1/2001

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Physical		1. Decedent's Name (First, Middle, Last) 2. Date of Death							UU/	3. Time of Death	
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs, I	ast birthday)	If Under 1 Year	LIS If Under 24 Hrs.	8. Date of Bir	rth			
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tems	Funeral	Armed F	edent Ever in U.sprces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	o- 14.	Race - Americ Black, White,		
and 21213-UU36 be filed within 72 hours after death with the Maryland stal Hygiene. Ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 【X Divorced Year or [2 📉 No ve lates:		1 □ Yes 2 K No	Specify:		Spi	ecify: Wh	ite	
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larylan 2 shouid be and Mental is marked of aumatic eve	မှ	19a. Informant's Name/Relationship (Type. Print)		19b. Mailie	ng Address (Street				own, State, Zip	Code)	
Baltimore, Maryland 21 bernit. Pages 1 and 2 should be filed w poparament of Health and Mental Hygier mopotant: If item 27 is marked other th any Injury or other traumatic event, the		John R. Eastman / Son			Winston						
of He item		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from	State C	emetery, crei	osition (Name of matory or other place	ce)	Date		ion - City or To		
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baitimo permit. Page Department important: If any Injury o		21. Signature of runeral Service Licenses	1		2. Name and Address Solomo		_				
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Physician		Immediate Cause (Final disease or condition resulting in death) A. Due to (or as a ornsequence of): Sequentially list conditions b. M+f									
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uted d ansit	Examiner	Sequentially list conditions, b. Director cause. Enter Underlying Cause (Disease or injury that initiated events									
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	by P	Part II. Other significant conditions contributing to o	leath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	obacco use contribute to the cause of death?			
ould b	ted t	Pulmonar-/ hy	Dertens	sium,	air	, 9/	1 🗆	Yes 2□N	lo 3 Pro	bably 4 Unknown	
VITAI HECOLDS, sician: The law requires t certificate has been signe rector, page 2 should be o	Completed	fibrillation					24a. Was	ppsy _	prior to co	ppsy findings available impletion of cause of	
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Attending F death. ctor: After y the funera	atio	1 _ flatural 5									
DIVISION I or Attending after death. Director: After din by the fune	Certification:		e of injury - At ho ling, etc. (Specif		reet, factory, office			(Street and N own, State)	et and Number or Rural Route Number, State)		
DIVISION OF VITA Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To th	e best of my kno	wledge, deal	h occurred at the ti	me, date and plac	e, and due to the	e cause(s) an	d manner as	stated.	
DIVISIO To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the ti	Medical	(Check only 2 Medical Examiner: On the	pasis of examina nner stated.	tion and/or ir	nvestigation, in my o	opinion, death occ	urred at the time	e, date and pla	ace, and due t	to the cause(s)	
To the within 2 To the complet	Ž	29b. Signature and the of certifier	DAN		29c. Licens	e number		29d. Date si	igned (Month,	Day, Year)	
Cino		1 Ala Tha	1111)		1000	18491	8	11	17	107	
1000m		30. Name and address of person who completed cau	se of death (Item	n 23a) (Type,	Print) 200	1 Medic	al Par	kway	Annap	olis MD	
Sta	ate	31. Date filed (Month, Day, Year) 32.	egistrar's Signa	ture	1					21401	
Regist	rar	NOV 0 8 2007	Kolen .	Dr. Ag	per						

Physician /Medical **Examiner** Physician/Medical Examiner

Physician

/Medical

Examiner

Directo

by Funeral

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

requires that the death certificate be executed burial-tran

use for ed by the a detached f signed b within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Medical Certification: To Be Completed by

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

shock, or heart failure. List only	y one cause on each line.	ANY ANA	r respiratory arrest,	Interval Between Oaset and Death
Immediate Cause (Final disease or condition resulting in death)	a Malignant Ol	Sjur		
	Due to (or s a consequence of):	/		√
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence or):			
resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown		opic pregnancy ner (specify)	23	d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
		·	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	B□ DOA Other: 4□ Nursing Ho	me 5 Residence 6 i	□Other (Specify)
27. Manner of ath 12 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not 6 ☐		factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	Physician: To the best of my knowledge, death occ amlner: On the basis of examination and/or invest and manner stated.			
29b. Signature and title of certifier (Chief Medical Officer	29c. License number	29d. Date	signed (Month, Day, Year)
Hospice of t	he Chesapeake	D 21438	N	00 05 07

DHMH 17 Rev 1/2001

State Registrar

Michael J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 0 7 2007

			For State Registrar	State of Ma	aryland			nt of He te of D		-	giene Reg. No.	007	00010	
			1. Decedent's Name (First, Middle, Last)							2. Date of Death		UU/	3. Time of Death	
	Physicia	Edward M Exicite								November 13		Year 2007	7:20A M	
*** **********************************		aminer 4a. Facility Name (If not institution, give street and number)						, Town, or L	ocation of Death			unty of Death		
188		-	17 Lake Potomac	ake Potomac Court					Potomac			Montgomery		
	Funeral		Social Security Number 6	6. Sex 7. Age (In yrs. last birth)				If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day, Year)		nplace (State or Foreign untry)	
	Director		569-14-3284	1⊠M 2□F	91	Yrs.	Worth		Tiouro Mini.	May 29,	1916		Maryland	
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation					_	10d. Inside City Limits	
	laryla shor	'n	,		,			ъ.					1 □ Yes 2 ☑ No	
	the M	Director	Maryland Montgom 10e. Street and Number	ery			10f 7	ip Code	omac		10g Citizen	of What Co	untry?	
	with a or			C			101. 2.	p oode	2005/		rog. Ottizon	U.S.	·	
	eath	era	17 Lake Potomac 11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. \	Was Dec	edent of His	20854 panic Origin? (Sp	pecify Yes or No	₎₋ 14.	Race - Amei		
	fter d r Iten iner	Funeral	1 □ Never Married 2 ☑ Married	Armed Forces?					panic Origin? (Sp , Mexican, Puerto	Rican, etc.)		Black, White	e, etc.	
99	urs a al', o Exam	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2☑ No Specify:					Spe		ecify:	white		
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	ted	15. Decedent's (Specify only highest	I	16a. Decedent's Usual Occupation					ing 16b. Kind of Business/Industry				
2	thin ie.	nple	Elementary/Secondary (0-12)	College (1-4or 5	(Give kind of work done during most of work life. DO NOT use retired)									
2	ed wi ygier yer th	So		4		Civi	1 Eng		40.44.4.4.4			Gover	nment	
Maryland	be fill Hall Hall Hall Hall Hall Hall Hall H	Be Completed	17. Father's Name (First, Middle, La						18. Mother's Nam			rname)		
3	d Mer narke	욘	Carl A. G. Fri			10b Mailie	a.a. A.daleaa	o (Street o	r anı nd Number or Ru	ny Talbot		own Ctata T	Zin Cada)	
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship				-	•					up Code)	
e,	1 an Heal em 2		Edward Frisius -	Son	20b. Plac	ce of Dispo	sition (Na	ame of	Court, Po	Date Pla		tion - City or	Town, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			-		Condon	1	.5/2007	01.00	. Morar	land	
Ħ	artme artme ortan Injur		21. Signature of Funeral Service Li		Judea			Garden and Address		.572007	Officy	y, Maryl	Lanu	
Ba	Dep Impe		Hines-Rinaldi Funeral Home, Inc.								ryland 20904			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
	Physician	i n	Immediate Cause (Final									Onset and Death 62 years		
ä	/Medical		disease or condition resulting in death)							02 years				
	Examiner		Occupation list and disions	b										
3	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisabs or injury that initiated events	a consequence of):										
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Box	death certifi e attending p id for use as	Physician/M	in the past 12 months?										Month Day Year	
P. O.	0 0 0	ıγsi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown										
	iaw requires that the de as been signed by the a 2 should be detached f	by Pl	Part II. Other significant condition	s contributing to death b	ut not resulti	ing in the u	nderlying	cause give	n in Part I.	23e. Did	23e. Did tobacco use contribute to the cause of dea 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Uni			
ğ	quire n sig uld b	d be	Pulmonary emboli							1 🗆				
S	aw requir s been si 2 should b	lete	Arteriosclerotic H	Heart Disease					24a. Wa				utopsy findings available	
Ä	The lay ate has bage 2	Completed	Congestive Heart I							autopsy performed? prior to completion of ca death? 1 Yes 2 No 1 Yes 2 No				
ital	lan: rtifica tor, p	Be C	25. Was case referred to medical	aritie					26. Place of Dea					
or Vital Records,	Physiclan: The is this certificate ha ral director, page 2	To E	examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 ☐ Inpatie	ent 2 ⊟ El	R/Outpatier	nt 3 🗆 🛭	OCA Othe	r: 4 □ Nursing H	ome 5⊠Res	idence 6 [Other (Spe	cify)	
	- 0		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		28b. Time of 28c. Injury at Work?				28d. Describe how injury occurred				
Sio	Attending r death. ector: After by the fune	catic	2 ☐ Accident investiga	ation			M		'es 2□No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)					street, factory, office 28f			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	phtal		29a. Certifier 1 ☑ Certifying	Physician: To the best	of my knowl	ledge deat	th occurre	nd at the tim	e date and place	and due to the	canse(s) ar	nd manner a	estated	
	24 hc 24 hc Fun etely	Medical		xaminer: On the basis of and manner sta	of examination									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			-	29c. License number				29d. Date signed (Month, Day, Year)			
	20		15		DO0 10205			11/1	11/13/07					
7	LU		30. Name and address of person w	ho completed cause of d	leath (Item 2	23a) (Type,	Print)						-	
_			Stanley Silve	erberg, M.D.,	5454 Wi	sconsi	n Ave	nue, Su	ite 925,	Chevy Cha	se, Mar	yland 2	0815	
. 100	Sta Registr		31. Date filed (Month, Day, Year)	2007 32 legistr	rar's Signatu	ire	astr.	P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08440 State of Maryland / Department of Health and Mental Hygiene Krey Jermaine Green 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 30, 2007 1037 hrs Krey Jermaine Green Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Crownsville **BGE Crownsville Substation Access Road** If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Min Davs County ryland Director 23 1 X M 2 F Yrs Ju1v 31 198 213-27-3869 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 Yes 2 X No or 28a-f show Maryland Anne Arundel Severn 23a or 28a-f sho notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 8623 Pioneer Dr. USA 21144 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: Divorced If Yes. Give Year ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) d other than ", 21215-0036 U S Food Service Warehouse Worker 11th 0 of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brenda Dicas

19b. Mailing Address (Street and Number or Rural Route) umber, City or Town, State, Zip Code) is marked traumatic event, Kevin Green 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Baltimore, Md. 21207 De Andre Diggs(Brother) Waldon Cherry Ct tant: If item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 XCremation 3 Removal from State Metro Crematory 11 - 8 - 07Baltimore, Md. Donation 5 Other Specify: Withame and Address of Facility Sons Mortuary, 21. Signature of Funeral Service Licensee West St. Annapolis, Beese 100483 Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and Death /Medical a. Gunshot wound of head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED by the attending physician ached for use as the burial Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Yea 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death nast 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed be deta 1 Yes 2 V No 3 Probably 4 Unknown ģ σ. Completed Records, 24b. Were autopsy findings available 24a. Was an peen autopsy prior to completion of cause of death? performed² certificate has 1 🗸 Yes ✓ Yes 2 26 Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medica director, Division of Vital æ Other₄ Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 this 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death After Subject shot Certification: FOUND: Yes 2 🗸 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natura Pending Oct 30, 2007 1037 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State)
BGE Crownsville Substation Access Road, Crownsville, Suicide determined (Specify) Found in car in woods 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Casis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner On anner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif

OCME

Registrar

Mary G. Ripole MD.

31. Date filed (Month, Day, Year)

NOV 0 8 2007

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

let calle of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 31, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 6, Nov. 2:00 Ам Louise Gorham /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Sacred Heart Nursing Home Hyattsville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔽 F 97 Washington, D.C. Director 579-14-2644 Nov. 6. 1910 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1√ Yes 2 No Director D,C, Washington None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 1536 Marion St. N.W. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify Specify: Black 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Int: If Item 27 is marked other than Housekeeper Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked 1 any injury or other traumatic ewoone. Freddie Young Ella Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Gorham / Son 2021 Quebec St. 20783 Adelphi, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Nov.14.2007 Landover, Md. Harmony Memorial 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}Latney's Funeral Home 3831 Georgia Ave. N.W. Wash., D.C. 20011 MD#278 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease Due to (or as a consequence of) Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Diabetes Mellitus 1 ☐ Yes No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No 1∐ Yes 25. Was case referred to medica examiner? director. Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner and

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed physician attending þ signed to been certificate l After this

Physician: Hospital or Attending within 24 hours after death To the Funeral Director: filled in by completely

Division or Vital Records, P.O. Box 68760

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Esmerando O. Juanitez, MD

and manner stated.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Exitiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D051122

29c. License number

1160 Varnum St. N.E. WAshington, D.C.

29d. Date signed (Month, Day, Year)

Nov. 12, 2007

State of Maryland / Department of Health and Mental Hygiene Jarrel Cortez Gray Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year November 18, 2007 0733 hrs Jarrel Cortez Gray **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Frederick Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Foreign Maryland Months Days Hours 220-13-4398 March 27, 1987 Director 20 1 X M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Frederick Maryland Frederick Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10g. Citizen of What Country 10f. Zip Code 21703 10e. Street and Number USA 7149 Ladd Circle 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married Yes **Black** 1 Yes 2 X No specify: Specify: If Yes, Give Yeer 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Commerical cleaning Cleaning 1 4 1 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tanya Thomas Jeffrey Gray event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Repederick Maryland 21701 19a. Informant's Name/Relationship (Type, Print) 342A Highview Terrace, Frederick, Maryland If item 27 is Jeffrey Gray - father 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) /28/07 1 Burial 2 Cremation 3 Removal from State Frederick, Maryland Resthaven Memorial Gardens permit. Pages Department of Important: 4 Donation 5 Other Specify 21. Signature of Fund ral Service Licer 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 2170 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Sudden death associated with restraint and alcohol intoxication Immediate Cause (Final disease taminer or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit sician/Medical icate has been signed by the attending physician page 2 should be detached for use as the burial XUNPENDED perME.g877 3/12/08 TI Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions þ 1 Yes 2 ✓ No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 1 🗸 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Be Other4 Hospital: Nursing Home 5 Residence 6 Other 2 CR/Outpatient 3 DOA Inpatient 1 V Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural Yes 2 X No unk Pending 5:03 am 11/18/2007 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State)
7102 Greshem Ct. East Frederick, MD determined parking lot Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 18, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. Registrar's Signature State 6 2007 BUS-Registrar

			For State Registrer		State of N	naryland	17 Depa <i>Cer</i>	artment of H tificate of I	lealth and Death	Mental Hyg	eg. No.	07	38216			
	Dhusia		1. Decedent's Name (Firs	t, Middle, La:	st)					2. Date of Dea Month	Day	Year	3. Time of Death			
	Physici /Medi		Percy Edward Galey, Jr.					Novemb			er 12, 2007 1:50		1:50 A M			
	Examir								4b. City, Town, or Location of Death			4c. County of Death				
								Montgome		-	Montgomery 9. Birthplace (State or Foreign Country) 1922 Pennsylvania					
	Funeral Director		5. Social Security Number 287–18–5735 Usuat Residence of Dece	1	ex 7.7	Age (In yrs. Ia 85		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.							
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	or 284	Director	10e. Street and Number					10f. Zip Code		1	0g. Citizen of V	What Cour	ntry?			
	death with the Maryland ma 23e or 28a-f ehow must be notified at	aiD	18700 Walker	rs Cho	ice Rd. #	314		20886		U	SA					
36	or its	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 X0		12. Was Deceder Armed Force 1 Xes 2 [If Yes, Give	s?] No	li li	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 XNo		Specify Yes or No- to Rican, etc.)		ce Amend ck, White,	etc.			
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pu		Be	17. Father's Name (First,							me (First, Middle,	Maiden Surnan	ne)				
yla	2 should be and Mental Is marked o	ဥ	Percy Edward	d Gale	y, Sr.				Matilda							
Mar	2 sh and and Is m		19a. Informant's Name/R	elationship (Type, Print)		19b. Mailin	g Address (Street a	and Number or A	ural Route Number	, City or Town,	State, Zip	^{Code)} 20886			
e,	1 end dealth		Katrine Gale		er/daught	er	18700	Walkers	Choice F		Montgon 20c. Location -		Village, MD			
Baltimore,	nt of the		1 ☐ Burial 2 ☐ Cree	mation 3	Removal from Stat			sition (Name of natory or other place Cremato								
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Ba	permit. Pages 1 and 2 should b Department of Health and Mente Important: If Item 27 Is marked eny Injury or other treumatic e once.		1/3000	4.1	The Util	⊬ .> MO12	GG 51 D	oing Home	Cremati	lon Servi	ce P.C). Bo	x 784			
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			resulting in death)	-		CIETOT is a conseque		rdiovascu	ilar Dise	ease		_				
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σ.	that ned by deta					y Ph	Y P	Part II, Other significent	conditions c	ontributing to death	but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did to	23e. Did tobacco use contribute to the cause of
Division of Vital Records,	w requires that been signed b should be dete	Completed by	Hypothyroidism						1 🗆 Y	es 2 No	3 🗆 Prob	oably 4 Unknown				
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Ä	The lav	Eo								autops perfor	ned?	prior to condeath? 1 Yes				
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sio	uttendii death. ctor: A y the fu	cati	2 Accident	investigation Could not be					M 1 Yes 2 No							
ΣĬ	or At after of Direct in by	Certification;	4 Homicide 3 Succide determined 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			il Route Number,			
	ours a		29a. Certifier 1 🛣	ertifying Ph	ysician: To the bes	st of my knowl	ledne death	occurred at the tim	a date and place	and due to the o	auco(a) and ma	20001 20 0	tatad			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	(Check only 2 N	ledical Exan	niner: On the basis and manner	of examinatio	on and/or inv	estigation, in my or	pinion, death occu	irred at the time, d	ate and place,	and due to	taled. the cause(s)			
	To th withir To th comp	Me	29b. Signature and title of	certifier	`			29c. License	e number	2	9d. Date signe	d (Month,	Day, Year)			
			Pail	Cow,	-			DY	1162	1	Vove	: Ch he	~1220c7			
124	do		30. Name and address of Vinu Ganti,		completed cause of	death (Item 2 ctor *s	23a) (Type, 1 Drive	Print) e Germant	own, MD	-						
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-		•	State Registrar	,		Cert	tificat	e of i	Death		Reg. No. 20	07	3821/
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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, o	Location of Dea	ath	4c. County	of Death	
			5271 Sudley Rd.						River				undel
	Funeral Director		218-30-3077	7. Age (Ir	_	6 Yrs.	Months	Days	If Under 24 Hi Hours Mi	n. Dec 1		9. Birth Cou Mar	place (State or Foreign ntry) yland
	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City,	Town or Loc	ation						10d. Inside City Limits
	Maryl f sho	ò	Maryland Anne Ar	undel	We	st Ri	iver	•					1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number				10f. Zi	Code			10g. Citizen of W	hat Cou	ntry?
	th wit 23a o 1st be	a D	5271 Sudley Rd.					20	778		US	SA	
136	be filed within 72 hours after death with the Maryland tat Hygiene. And other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.				ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	Blac	e - Ameri k, White : B1	
ž	2 hou latura		15. Decedent's Edu	cation		16a. Decede	ent's Use	al Occup	ation	varkina	16b. Kind of Bu	siness/Ir	ndustry
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2	filed wi Hygien Ither th	် ပ	6th	0		Do	omes	stic	40 14-41-3-1	1 /Final Adiab			Family
Ē	be fill ntal H ed oth even	æ	17. Father's Name (First, Middle, Last) Frederick Ha	11						ity Joh	le, Maiden Surnam	ie)	
Maryland	should be to the should	٤	19a. Informant's Name/Relationship (Ty	ne Print)	1	19h Mailing	n Δddras	s (Street			inson ber, City or Town,	State Z	in Code)
<u>∞</u>	id 2 s ith an 27 Is i traui		Bessie M. Abel(,	`					ver, Md.		
	ss 1 and 2 should by Health and Ment item 27 Is marked rother traumatic		20a. Method of Disposition			ce of Dispos netery, crem				Date	20c. Location -		
e E	Pages nent of I ant: If its ury or of		1 🖾 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (<i>Specify</i>)	removal from State 1		Zio				-8-07	Lothia	ın,	Md.
Baltimore,	permit. Page Department (Important: If any injury or once.	l i	21. Signature of Funeral Service Licens	ee							uary, F		
ñ	a II De	0 3	Jany B. Ale	se 110098	3	82	21 V	Vest	St. A	nnapoli	s, Md.	214	01
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	ding Ph h. After th funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear)	Injury	М	28c. Inju Wo 1 □	rk?ົ`]Yes 2∐No		o non mjary occa.		
	the Hospital or Attending thin 24 hours efter death. the Funeral Lirector: After mpletely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At hon (Specify)	ne, farm, stre	eet, facto	ry, office			(Street and Numb Town, State)	per or Ru	ıral Route Number,
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	J4"		30. Name and address of person who of	JONES,	m	0	Print)	35	-A	nence	310	23	5
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07-08471 Jerome D. Hughes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ome D. Hughes		State of Maryland / Department of Health and Menta Certificate of Death	Hygiene Reg.	No. 200	7 38211
Di dalam	Re	edistrar . Decedent's Name (First, Middle,Last)	2. Date of Death	3.	Time of Death
Physician dical Examine	-	Jerome D. Hughes	Month D October 31,		1933 hrs
Calcul Examine	48	ta. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D	Death	4c. County of Death	
		Anne Arundel Medical Center Annapolis		Anne Arundel	Jana (Chata as
Funeral	5.	Social Security Number 6. Sex	24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthp Foreign	
Director	1	213-25-9884 1XM 2 F 18 Yrs. Months Days Hours	July 20) 1989 Coun	try) D.C.
_	- 1	Isual Residence of Decedent		11	0d. Inside City Limits
any	1	10a. State 10b. County 10c. City, Town or Location			1 Yes 2 X No
show nd	⊨ M	Maryland Anne Arundel Glen Burnie		. Citizen of What Countr	
faryla	υl	10e. Street and Number 10f. Zip Code	109		1
the N sa or		306 Colby Circle 21060	2 (Specify Vos or No-	USA 14. Race - America	an Indian, Black,
r death with the Maryland or items 23a or 28a-f show any must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	White, etc.	
deatl	뒤	Yes 2 11 No		Specify: Blac	ck
s after ral",	⋧┞	3 Wildowed 4 Divorced or Dates: or Dates: 1 16a Decedent's Usual Occupation (Give ki	III OI WOIN GOILO	16b. Kind of Business/In	dustry
hour	됩니	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	ise retired)		
36 nin 72 Hhan dical	Completed	10th 0 None		Unemploye	ed
d with	탉	17. Father's Name (First, Middle, Last)	Name (First, Middle, M		
215 e file tal H ked o	<u>۾</u>	Berej Hirrori	rressa Hu	ghes	Zip Code)
21 ould by Mer	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numt			
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than unantic event, the Medica		Territa Peace(Aunt) 306 Colby Circle 20a Method of Disposition [20b. Place of Disposition (Name of cemetery, 1.20b. P	e Gien Bui	20c. Location - City or	Town, State
Fe, 1 and Fitten Fitten Fitten er tra		crematory or other place)	11-9-07	Annapolis	s Ma
Pages lent o unt: J	- 1	4 Donation 5 Other Specify:			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	T	21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 821 West St.			
ο ខេច្± :	K	Tarry 12. Aces Moc483 821 West St. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	ardiac or respiratory arre	est, shock, or heart	Approximate Interval
Physician Medical	ľ	failure. List only one cause on each line.			Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
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Ox 6876C eath certificate e attending phys for use as the b	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectoping as 12 months? 4 Pregnant at time of death 5 Other (Specify)	о раздания,	4	
Box 6876(death certificate the attending phy ed for use as the t	Physician/M	1 Yes 2 No 9 Unknown g Unknown			the section of the other
O.O. Be that the de ned by the detached f	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.		obacco use contribute to	
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Division ospital or Attend hours after death meral Director:	Certification:	4 V Homicide determined (Specify) Sidewalk			
Division of Y To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral			occurred at the time, dat	e and place, and due to	the cause(s)
To the Ho within 24 To the Fu	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (N	
	2	O.C.M.E.		November 1, 2	007
		30. Name an arress of person who completed cause of death (Item 23a)			
1/10		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
(1997)	itate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis		ar NUV U 7 2001 places to goods			
DHMH 17 Rev 1/	2001	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend lines 7 & 8 per fd aaco hlth dept 11/13/07 dlw State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Margaret Howie 4:00 pM November 4. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 105 Melchior Road Millersville If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 936 North Carolina 241-44-3309 1931 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at MD Anne Arundel Millersville 1 ☐ Yes 2 ☑ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 105 Melchior Road 21108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No 2 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifford Hines Helen Allen Is marked ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William O. Howie/Son Millersville, MD 21108 105 Melchior Road item 27 Important: If item 27 any Injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 23a. Dart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical as ed by the attending I detached for use as IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknowed signed I d be det 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No funeral director, page 2 autopsy certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Inpatient ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? Certification: Injury Natural 5 Pending 1 ☐ Yes 2 🗆 No investigation within 24 hours after death

To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mas p. Tal Grive Glew Burne MS 2006 203 GUV 5017 780 strar's Signature 31. Date filed (Month, State

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 November 3:39 A M Robert William Hoffman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York Social Security Number 6. Sex 1 X M 2 ☐ F Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 060-30-3069 70 Director 4/20/1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Anne Arundel Director Maryland Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 165 Fiddlers Hill Rd. 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4_years Partner <u>Real Estate</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Bertram Hoffman Constance Turner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 165 Fiddlers Hill Rd., Edgewater, MD 21037 Mary M. Hoffman/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Kalas Crematory 11/9/07 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, MD 21. Signatura Funeral Service Lio 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD **Physician** 7 lycar /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2**X** No 1 Tyes 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? he Hospital or Attending P n 24 hours after death. he Funeral Director; After t pletely filled in by the funera 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D248-64 MD

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** RAYMOND 2007 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1⊠M 2□F 579-52-3548 Director Jan. 22, 1941 DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 50 Underwood Street, NW 20012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver US Army 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: If Item 27 is marken any Injury on a state of the s 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond M. Haynes, Sr. EVelyn Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melba Haynes/Wife 50 Underwood Street, NW Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National 11-13-2007 | Triangle, VA 22 Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th Street, NW Washington, DC 23a. Pa. J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s o k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCIEROTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of r Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy perform 2D No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 Inpatient 2 ER/Outpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Switkes 2007

29b. Signature and title of certifie

DASHEDOSTON ADVISITEST HOSPITTAL,

MID

DHMH 17 Rev 1/2001

29c. License number

10055

TAKOMA-PARK, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Facility Name (If not institution, give street and number, Çity, Town, or Location of Death County of Death Examiner rester lnter PY USH If Under 1 Year 8. Date of Birth (Month, Day, Year) JAN. 27, 1923 Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F MARYLAND Director 217-16-4203 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 600 FOGWELL ROAD 21617 USA filed within 72 hours after death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. ģ 3 Widowed 4 Divorced "naturai". WHITE Completed Medica 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the FACTORY WORKER -0-FOOD other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental marked JAMES GRAP MOLLY GRIEMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health VERNON HANDEL/ HUSBAND 600 FOGWELL ROAD, CENTREVILLE, MD 21617 Department of Heal Important: if item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CHESTERFIELD CEMETERY 11-13-2007 CENTREVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical many Viscust Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4 ☐ Pregnant at time of death 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy Hypothy/oid, sm Division or Vital 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes Certification: To 2 ER/Outpatient 3 DOA npatient 27. Manner of Death 28b. Time of Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funerai D Medical Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar of death (Item 23a) (Type, Print)

			For State Registrar		i wai yia		rtificate of			Reg. No 2	007	38221
	Physici	an	1. Decedent's Name (First, Midd						2. Date of Do Month	Day	Year	3. Time of Death
	/Medic	al	Elaine L. Ha				4h City Town a	and another of Dool	Novemb		2007 Sounty of Death	10:30 A.M
	Examin	er	4a. Facility Name (If not institution 12111 Hitch	-			Rocky	or Location of Deal	(1)			
47.00	Funeral		5. Social Security Number	6. Sex		s. last birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth	Iontgome 9. Birth	place (State or Foreign
44	Funeral Director		578-28-7674 Usual Residence of Decedent	1□M 2(X F		79 Yrs.	Months Days	Hours Min.	Jan. 1	ay, Year)	Cou	v York
/land	at at		10a. State 10b. County	,	10c. (City, Town or L	ocation					10d. Inside City Limits
the Man	28a-f sh	ector	Maryland Monts 10e. Street and Number	gomery	R	ockvil]	Le 10f. Zip Code			100 Citiza	en of What Cou	Y Yes 2 No
ath with	23a or ust be r	Funeral Director	12111 Hitching	Post Lane			208.				U.S.	Α.
36 is after de	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Fune	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	14 V++ O:	orces? 2 X No ve	U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or Norto Rican, etc.)		1. Race - Ameri Black, White Specify: Whi	, etc.
Maryland 21215-0036	"natura edical E	Completed by	15. Decede (Specify only high	nt's Education est grade completed)		16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of wo	orking	16b. Kind	d of Business/Ir	ndustry
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d fied	Hygi other ent, t		17. Father's Name (First, Middle	, Last)				18. Mother's Na	me (First, Middle			
la be	ked c	To Be	Theodore Gold	lberg				Rosa	lind Fis	sher		
Mary id 2 shou	Ith and M		19a. Informant's Name/Relation Nancy S. Merri		ter		ing Address <i>(Street</i> 3 Overlea					ip Code) 20850
Baltimore, permit. Pages 1 ar	Item other		20a. Method of Disposition	- X-	20b	. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace)	Date	20c. Loca	ation - City or T	own, State
imo Page	ant: If		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (id Mem. G		14/2007	Fall	s Churc	ch, Virgini
3alt ermit.	nport ny inj		21. Signature of Funeral Service		,	Î	2. Name and Address	ess of Eacility -Goldber	g Memori	al Ch	apels,	Inc.
	. O . D . E . O .	Н	Conald. C.	Stottle	mye	2]	L170 Rock	ville Pi	ke, Rock	ville	. Maryl	Land 20852 Approximate
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	t only one cause on e	each line.	eath. Do not er	iter the mode of dyl	ng, such as cardia	ic or respiratory	arrest,		Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)				rt FAilur	e				Months
	xaminer				(or as a cons	equence on: Tibrilla	ation					
		je.	Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events		(or as a cons		2011					
cuted	nd ransit	Examiner	Cause (Disease or injury that initiated events	с. Ну	perter	sion						
68760, tificate be executed	g physician and as the burial-transit		resulting in death) Last	Due to	(or as a cons	equence of):						
68760, ficate be ex	hysic the bi	edical		d								
I Records, P.O. Box 6 The law requires that the death certific	ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	4□Pregi	birth 2□F nant at time o	etal death 3	□Ectopic pregnanc	у		23	Bd. Date of delive	very Day Year
O at	by the	hysi	9 Unknown	9□Unkn	iown							
JS, F	been signed the should be det	by	Part II. Other significant condit	ions contributing to d	leath but not r	esulting in the	underlying cause gi	ven in Part I.		tobacco use		the cause of death? bbably 4 □Unknown
Orc	hould	eted										
Records, he law requires t	e has	Completed		·					perl	opsy formed?	prior to co death?	topsy findings available ompletion of cause of
			25. Was case referred to medic	al				26. Place of De	1 Yes eath (Check only	2X No	1 ☐ Yes	2 No
V Sicle	s cert direct	To Be	examiner? 1X Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ott	h +	Home 5 K Res		□Other (Spec	eifv)
Vision or Vita Attending Physician:	er this		27. Manner of Death	28a. Date		28b. Time			28d. Describe			,,
ior andin	ath. or: After ne funer	atio	Z L Accident	igation	in, buy rous	,,,		Yes 2 □ No				
Division or all or Attending Phys	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 200. Flatte	e of injury - Al ling, etc. <i>(Spe</i>		treet, factory, office			(Street and own, State)	Number or Ru	ral Route Number,
Div To the Hospital or	e Funer e Funer etely fille	Medical (29a. Certifier 1 Certify (Check only one) 2 Medica	ng Physician: To the I Examiner: On the b and man	e best of my loasis of exam nner stated.	knowledge, dea ination and/or i	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) a e, date end p	and manner as place, and due	stated. to the cause(s)
To th	within 2 To the complete	Me	29b. Signature and title of certific	er			29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
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l			30. Name and address of erso Dean Dwyer	·				Chevy Ch	ace Mea	rv1 and	1 2081	5
	Sta	ite	31. Date filed (Month, Day, Yea.) 32°F	Registrar's Sign	gnature	Avenue,	onevy on	Les ria	Lyranc	. 2001.	
	Regist	rar	NOV 14	2007	Registrar's Sig	be for	SPERE					
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			FOF	Maryland		artment of F		Mental Hyg	iene		
	_		State Registrar Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of Dea	eg. No.2	007	38225
	Physicia /Medic	_	ELEANOR	K	t	+ OCL A	NO	Month	86	Pear 7	0157 M
	Examin	er	4a. Facility Name (If not institution, give street and num				r Location of Death	ı		unty of Death	
			Anne Arundel Medical Cen 5. Social Security Number 6. Sex	er . Age (In yrs. I	ast birthdav)	Annap		8. Date of Birth		ne Arun	lace (State or Foreign
	Funeral Director		089-24-5031	83	Yrs.	Months Days	Hou <i>rs</i> Min.	7/21/1	924	Flor	ida
back	ow at		10a. State 10b. County	10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
Man	a-f sh lifted	ctor	Maryland Anne Arundel		Ar	napolis					1 LaYes 2 No
th th	or 28 be no	by Funeral Director	10e. Street and Number			10f. Zip Code	01	1	0g. Citizen	of What Coun	try?
t d	is 23a must	eral	1312 Homewood Ln. 11. Marital Status 12. Was Dece	ent Ever in III	S 13	214		necify Yes or No-	14.	USA Race - Americ	an Indian.
40.0	r Item	Fun	Armed For	es? 2[X No		Was Decedent of H If Yes, specify Cub:		o Rican, etc.)		Black, White,	
3-0036	ral", o		3 X Widowed 4 ☐ Divorced If Yes, Give Year or Da	es:		1□Yes 2ሺDNo	Specify:		Sp	pecify: Wh	ite
<u>ה</u>	penint. Tages I and Salven delice within 2 hours are local with the inaryiand important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king	16b. Kind	of Business/Inc	dustry
7 7	iene. r than	отр	Elementary/Secondary (0-12) College (1- 2 yea			cutive Se			Feder	ral Gov	ernment
ם פּ	al Hyg other	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Su	rname)	
yland yland	Ment arked atic e	70	David Costello					la Baron			
Mar	traum		19a. Informant's Name/Relationship (Type. Print) Paul J. Holland/ Son			ng Address (Street Homewood					Code)
a	Heali Heali tem 2		20a. Method of Disposition	20b. P	<u> </u>	osition (Name of matory or other place		Date		ion - City or To	wn, State
OL	nt: If i		1 ☐ Burial 2 X Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)			matory or other plac Crematory		7/07	Edgev	water,	MD
Baltimor	Departm Departm Importa any Inju once,		21. Signature of Fandral Service Licensee		22	2. Name and Addre	ss of Facility Ge	eorge P.	Kalas	s Funer	al Home
ם פ	82 6 8 9		Mull			2973 Solo				ater, M	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final	-	. Do not ent	ter the mode of dyir	M MORA	or respiratory arr	est,		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition a.	r as a consequ	ience of):	1,11	MINIOIL	46			5 0)
E	xaminer			,	,						
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oo / oo,	/siciar e buri										
00	ng phy	Medi	IF FEMALE:								
XOD TO	attendi for use	Physician/Medical	23b. Was decedent pregnant 1□Live bi	th 2 Fetal	death 3	Ectopic pregnanc	у		23d	I. Date of delive Month	ery Day Year
٠ ١	y the a	ysic	1 ☐ Yes 2 No 4 ☐ Pregnt 9 ☐ Unknown 9 ☐ Unknown	nt at time of de	eath 5L	Other (specify) _					
יי, דיין	within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Pi	Part II. Other significant conditions contributing to de	ath but not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
cords,	equilic ould b	ted		2	4			1 🗆 Y	es 2□X	o 3□ Prob	ably 4 Unknown
i ec	has be	Completed	- Typo +	yro	w			24a. Was a autop:	sy	24b. Were auto prior to cor death?	psy findings available npletion of cause of
VICION: Th	ificate or, pag	S C	25. Was case referred to medical				Ge Blood of Dog	1 Yes	med? 2 No	1 ☐ Yes	2□ No
Veicis	is cert direct	To Be	examiner?	patient 2 1	ER/Outpatier	nt 3 DOA Oth	or:	lome 5 ☐ Resid		Other (Specif	y)
	fter th		27. Manner of Death 28a. Date of		28b. Time o Injury	f 28c. Inju		28d. Describe h			
JIVISION	tor: A	catio	Z Accident investigation	of inium. At ho	ma form at		Yes 2 □ No	DOS Location (C	4-n-n-1 n 1 h		/ 5
	after d Direc	Certification:		g, etc. (Specify	me, iarm, su	reet, factory, office		City or Tow		umber or Hura	I Route Number,
_ critical	hours hours neral ly filled		29a. Certifier (Check only 2 Medical Examiner: On the ba	pest of my know	wledge, deat	h occurred at the ti	me, date and place	e, and due to the d	ause(s) an	d manner as s	tated.
H off	the Fi	Medical	one) and mann		ion and/or in						
Ę	Z with	-	296. Signature and title of certifier	Aau	1	29c. Licens		128 1	Marie s	igned (Month,	Day, rear)
•	WaC/	لو	30 Name and address of person who completed/cause	of death (Item	23a) (Type,	Print)	V 2 17	-11-	140	4	on 2007
*	Sta	to-	MICHMEL J. Late,	NTAI	w l		FENSE	1761 H	WHY	NNA	MINN DEIKA
	Sta Registr	_	HQV 0 8 2007	gistrar's Signa	× 60	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JOSEPH JACOBS, JR. 11 2007 05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. 578-42-8737 73 01/06/1934 WASHINGTON, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PRINCE GEORGE'S FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9101 CROSSBOW ROAD 20744 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married ☐Yes 2 f Yes, Give 1 ☐ Yes 2 🗓 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CHAUFFEUR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH JACOBS, SR. MAGGIE MASON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELSIE JACOBS/WIFE 9101 CROSSBOW RD., FT. WASHINGTON, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY | 11/10/07 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME war 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Presinenia Unknowy Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Un KADWa that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Carun 6-1/h 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy perform 2 No 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must t

72 hours after

filed within 7 Hygiene.

if Health and Mental Hygiene.

Department of Health and Menter Important: If item 27 is any lijury or off

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examine

The law requires that the death certificate be executed sician phys the t page 2 s Physician:

hours after death. uneral Director: A the filled in by

Division or Vital Records, P.O. Box 68760,

within 24 hours a To the Funeral D the Hospital Registrar

or Attending

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Route Farable D43446

DHMH 17 Rev 1/2001

9801 Georgia Are Juit 3-41

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D 32. Registrar's Sign ture

FARAM, FAR

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2w7 Month **Physician** JHNSON 500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Amold legville Anne 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 27 19 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign **Funeral** 17 M 2□ F Months Days Hours 220-16-8944 81 Director 1925 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location show r 28a-f show notified at 10d. Inside City Limits Maryland Anne Arundel 1 ☐ Yes 27 No Director Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1354 Shirleyville Rd. 21012 death v USA Funeral 12. Was Decedent Everiful.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 MYes 2 ☐ If Yes, Give Year or Dates: 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 9th 0 Ft. George Meade <u>Foreman</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilton McKinley Johnson ပ Mary Catherine Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores M. Johnson(Wife) 1354 Shirleyville Rd. Arnold, Md. 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 <u>M</u> Burial 2 □Cremation 3 □Removal from State Maryland Veteran | 11-12-07 Crownsville, Md. 4☐Donation 5 ☐ Other (Specify) Wanname Reasses of the cilions Mortuary, F.A. 21. Signature of Funeral Service Licenses Larry B. M00483 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Oshre Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-trar and Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician to detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 1 🗌 Yes 2 X No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy performed funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 22 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Injury 1 Natural Hospital or Attendi
 Hours after death.
 Funeral Director; A 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral L **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUP

29b. Signature and title)of certifier

Sale 300 Amapolis Bestycke egistrar's Signature

29c. License numbei

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death UU 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 **Physician** 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26 Wilelinor Drive Edgewater Anne Arundel ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 227-20-2467 Months Days Hours 1 X M 2 □ F 82 Director May 28, 1925 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Maryland Anne Arundel be notified Edgewater 1 ☐ Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be nooce. 26 Wilelinor Drive 21037 U.S.A. Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1x Yes 2 No If Yes, Give Year or Dates:1943-52 1 Never Married 2X Married 1 ☐ Yes 2K No. Specify: White ģ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh H. Jones, Sr. Helen F. Glaettli ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Jones/wife 26 Wilelinor Drive Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 11/13/2007 4 Donation 5 Other (Specify) Crownsville, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician 4 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): attending physician Physician/Medical ası IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → No 24a. Was an hast autopsy performed? Yes 2 No page certificate 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000 1 | Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Division or Vital Records, 24 hours after death Puneral Director: filled in by Hospital completely within 24

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

State Registrar

31. Date filed (Month, Day, Year) NOV 0 8 2007

29b. Signature and title of certifier

(Check only

900 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Rd Sute 300

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Deçedent's Name (First, Middle, Last) 2. Date of Death Month Day 1303 000 00 2007 જ 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Olmes mont montporner Ocon ROmer Age (In yrs. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours Min. 565 69 6967 Yrs FEB 24 1914 KOREA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Nes 2 No MD ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 3 HAMPTON CT USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specific 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SA OAK SUNG OAK PARK ANN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 HAMPTON CT ANNAPOLIS MD 21403 SEONG J KIM/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) MEADOW RIDGE MEM 11/2/07 ELKRIDGE MD 21. Signature of Fune 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (o as a conse weree of): Disten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 1□ Yes 25. Was case referred to medical examinar? 1 ▼ Ves 2 No clecime! 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

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Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 Is marked other the any Injury or other traumatic event, the inne.

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Examiner must be notified at

Director

Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner and bunal-tra attending physician for use as the buna ed by the a page 2 s

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be P

completely filled in by the funeral director Certification: s after death.

Hospital or Attending Physician: within 24 hours a

To the Funeral I the

State Registrar

27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 ☐ Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) Oct 28 2007

and manner stated

28b. Time of Injury 1200

Medical Directo

28c. Injury at Work?

1 ☐ Yes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Philip

050410

Choked on

Location (Street and Number or Rural Route Number City or Town, State) 51/ver 9pury 20906 mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed Month, Day, Year, 0 NOV

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State o	f Marylar			of Health of Death		1ental Hy	giene Reg. No.	07	38230
			1. Decedent's Name	(First, Middle,	Last)						2. Date of De	ath	Vana	3. Time of Death
	Physicia	_	Randall	C. F	(enyon						Month NOV.	4 Day	2007°	3:25 A M
	/Medic Examin		4a. Facility Name (If			mber)		4b. City, Tov	vn, or Location	of Death		4c. Cou	inty of Death	1
			Anne Aru	ndel Me	edical Ce	enter		An	napolis	5		An	ne Arı	ındel
	Funeral		5. Social Security Nu		.Sex 1⊠M 2□F	7. Age (In yrs.	• •		ear If Unde ays Hours		8. Date of Bir (Month, Da	th v, Year)	9. Birth	nplace (State or Foreign
	Director		132-22-51	94	IKIM ZLIF	77	Yrs.				Aug. 1	8,1930	N€	ew York
	w W	}	Usual Residence of I	10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	Aaryli f eho	٥	MD	Drince	George's		Bowie							Y☐Yes 2☐No
	the A	Director	10e. Street and Num		ocorge 2	<u>, </u>	DOWLO	10f. Zip Co	de			10g. Citizen	of What Co	untry?
	with 3a or	<u> </u>	12513 Sh		Lane				0715				USA	
	death The 2%	Funeral	11. Marital Status	ectara	12. Was Dec	edent Ever in U	J.S. 13.			rigin? (Sp	ecify Yes or No Rican, etc.))- 14. F	Race - Amer	
36	72 hours after death with the Maryland Insture!; or items 23s or 28s-f ehow disal Examiner must be publised at	by Fur	1 Never Marrie		If Yes, Gr			t Yes, specify 1□ Yes 2🛣			Hican, etc.)		Black, White ec <i>ify:</i>	WHITE
Ö	d within 72 hours a giene. er then "neturel", o			15. Decedent's	Education	1001-	16a. Dece	dent's Usual C	ccupation			16b. Kind o	of Business/l	
215	C * 100	Completed	(Specif		grade completed) College (1-40r 5+)	(Give	kind of work o DO NOT use r	lone during mo etired)	st of work	ang			
217	filed within Hygiene. other then	E	Clottle Hally/300011	odiy (o 12)	4		Ele	ctroni	c Engir	eer		N.	S.A.	
B	물수들병	Be	17. Father's Name (F	First, Middle, La	ist)				18. Moth	ner's Nam	e (First, Middle	, Maiden Sun	name)	
<u>Va</u>		2	Randall	Creight	on Keny	70n				gare				
Maryland 21215-0036	C1 10 -= 68	1 3	19a. Informant's Nar		,			-			al Route Numb		wn, State, 2 2071 !	
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סנ	S = 0		1 ☐ Burial 2 🖫	Cremation 3	☐Removal from	State	cemetery, crei	natory or othe	r place)				_	
Baltimore,			4 □ Donation 19			Me					5/2007 all Fun			, VA.
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			23a. Part1. Enter the shock, or hear	e disease, or co t failure. List or	omplications that only one cause on o	caused the dea each line.				s cardiac	or respiratory a	rrest.		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (F	Final 1	_ a		rne	anou	ua					3 wws
	/Medical Examiner		resulting in death)	1	Due to	(or as a conse	quence of):							
	¥	<u>.</u>	Sequentially list con	ditions.	b. — Due to	for as a consu	auence of:							
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9	rtifica ng ph as th	0	IF FEMALE:	-										
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0.	ed: bed:	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∐Pregi 9⊡Unkr	nant at time of lown	death 5[Other (speci	(y)	3.70				
<u>α</u>	res thet thighed by		Part II. Other signific	cant condition	s contributing to d	leath but not re	sulting in the u	nderlying caus	e given in Part	t 1.	23e. Did	tobacco use o	contribute to	the cause of death?
of Vital Records,	luires n sign ild be	d by							<u>-</u>		10	Yes 28N	io 3∏Pr	obably 4 Unknown
2	w requ	lete									24a. Was		4b. Were au	itopsy findings available
æ	The lav	Completed									auto perfe 1 ☐ Yes	psy ormed? 2 № No	death?	completion of cause of
ta		0	25. Was case referre	ed to medical					26. Plac	ce of Deat	th (Check only			
>	% ≥ ⊕	To B	examiner? 1 ☐ Yes 2 2 1	No	Hospital: 1	Inpatient 2	☐ ER/Outpatier	t 3 DOA	Other: 4 1	Nursing Ho	ome 5 Res	idence 6 🗆	Other (Spec	city)
	g e		27. Manner of Death 1 Natural	5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury		Injury at Work?		28d. Describe	how injury oc	curred	
Sio	Attending or death.	cat	2 Accident	investiga 6 ☐ Could no	the			М	1 Yes 2	No				
Division	N or Att	Certification:	4 Homicide	determin	ad 286 Place	e of Injury - At I ling, etc. <i>(Spec</i>	home, farm, st hity)	eet, factory, o	ffice			wn, State)	umber or Hi	ural Route Number,
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A ormpletely filled in by the fu	Medical C	29a Cariffier (Check only one)	Certifying 2 Medical E	Physician: To the taminer: On the tand man	a bast of my kn pasis of examin nner stated.	lawledge deat nation and/or in	h occurred at vestigation, in	he time, date t my opinion, de	and place eath occur	and due to the red at the time.	causa(s) and date and pla	mannar as	to the cause(s)
2-1	To the To the Complet	Me	29b. Signature and	title of certifier	miil.	(1.3		29c. L	icense number	0 0	,	1	- 1	h, Day, Year)
71	811		30. Name and addre	ass of nerson w	ho completed carr	se of death (Its	em 23a) (Tvn≏	Print)	1118	28			04/2	.007 , U1d.
4	911		Story U-	t E.	Selou	ich. C	wo	900	Bestv	juste	Rd. 1	tuna	polis	, Md.
	Sta Registi		NOV 0		Lieun	Registrar's Sign	Speck	•						W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		artment of F rtificate of			liene 007	38231
1	Physici	an	1. Decedent's Name (First, Middle, Last	,	V '			2. Date of Dea	th You	3. Time of Death
	/Media		Helen 4a. Facility Name (If not institution, give	Ann street and number)	Karis	4b. City, Town, o	r Location of Deat	November	4c. County of De	
1	Funeral	k n	Southern Maryland Hos 5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year	inton If Under 24 Hrs.	8. Date of Birth	Prince G	irthplace (State or Foreign
ķ.	Director		579–52–1656 Usual Residence of Decedent	□M 2 X F 67	Yrs.	Months Days	Hours Min.	Sept. 27,	1940 W	ountry) ashington, DC
	aryland show 1 at	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	the Market substitute of the Moutified	Director	Maryland Prince Geo	rge's	Oxon Hill	10f. Zip Code		11	0g. Citizen of What 0	1 ☐ Yes XIXJX No
	ath with s 23a or nust be		1146 Kennebec Street	#1		2074			USA	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 K(D\ever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	U.S. 13. \	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 27X No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
215-(nin 72 h in "natu Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor f)	rking	16b. Kind of Busines	s/Industry
121	iled witl Hygiene ther tha nt, the	Com	7th 17. Father's Name (First, Middle, Last)	College (1-401 5+)	Cust	odial Work		ne (First, Middle,	Private In	ndustry
/land	Mental I	To Be	John Karis						ring	
, Maryland 21215-0036	s 1 and 2 sho of Health and item 27 is ma other traums		19a. Informant's Name/Relationship (Ty John Karis / Son	pe. Print)		ng Address <i>(Street</i> Indian Head <i>I</i>			r, City or Town, State, faryland 20	Zip Code) 1640
Baltimore,	Pages 1, nent of He ant: If item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			sition <i>(Name of</i> matory or other plac norial Ceme		Date D/2007 W	20c. Location - City o Valdorf, Mary	
Balt	permit. Departr Imports any fnji		21. Signatur uneral Service Licens	Cas . C.		Name and Addre			as Funeral F ervland 207	
		. 07	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ications that caused the de ne cause in each line.	ath. Do not ente	er the mode of dyir	g, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a conse	equence of):	yndro-	<u> </u>			
Ê	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	eque de of):	m, 4				Days
60,	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	al Examiner	Cause: Life: Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	لاسمع	Carcar			more 2
c 68760,	rtificate ng physi as the	Medical	IF FEMALE:	l						
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3]Ectopic pregnancy] Other (specify)	,		23d. Date of do Month	elivery Day Year
rds, P	quires that in signed build be deta	ģ	Part II. Other significant conditions col	ntributing to death but not re	esulting in the un	nderlying cause give	en in Part I.	23e. Did tol		to the cause of death? Probably 4 □Unknown
Vital Records,	The law requir ate has been si page 2 should I	Completed						24a. Was a autops perfori	sy prior to	autopsy findings available ocompletion of cause of
Vita	sician: s certific lirector,	Be	25. Was case referred to medical examiner? 1 Tyes 2 No	lospital: 1 Inpatient 2	☐ ER/Outpatient	t 30 DOA Othe	or.	th Check onl on		
on or	nding Physician: The la th. :: After this certificate has s funeral director, page 2	tion: To	27. Manner of eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Worl			ence 6 Other (Sp ow injury occurred	есііу)
Division or	f or Atten after deat Director I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At building, etc. (Spec	home, farm, stre cify)			28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	a, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier			29c. License DO0639		2	9d. Date signed (Mor	
)	19		30. Name and address of person who co			Print)			11/6/2	:007
		20	Manesh Nachnani MD 31. Date filed (Month, Day, Year)	7503 Surratts		·	Land 207	735		,
	Sta Registr	_	NOV 0 7 2007	32. Registrar's Sign	Operte					

State of Maryland / Department of Health and Mental Hygien 2017

38232 Certificate of Death

1 = For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Month	Day		
an al	ANNABELLE RINGGOLD KUMINS		NOVEMBE		2007	7:34 P
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	ath	4c. County	y of Death	
	ANDRUS HOUSE	BETHESDA		MONTO	GOMERY	
	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda	Months Days Hours Mi		(, Year)	9. Birthpla Count NEW	
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10	d. Inside City Limi
tor	MARYLAND MONTGOMERY CHEVY C	HACE				1 X Yes 2 □ 1
Directo	MARYLAND MONTGOMERY CHEVY C 10e. Street and Number	10f. Zip Code	1	10g. Citizen of	What Count	ry?
	4701 WILLARD AVENUE APARTMENT 402	20815		UNITED		_
neral		3. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Rac	ce - America	n Indian,
/ Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give	If Yes, specify Cuban, Mexican, Put 1 Yes 2 No Specify:	erto ricari, etc.)		ick, White, e	
d by	3 ▼Widowed 4 □ Divorced Year or Dates:	TEL 165 ZINO Specily.		Specif	fy: WHI'	LE
ompleted	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of w	vorking	16b. Kind of B	Business/Indi	ustry
d L	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)				
O	12 HOM 17. Father's Name (First, Middle, Last)	EMAKER 18 Mother's N	lame (First, Middle, i	OWN HO		
o Be				аливт эитап	ne)	
٩	PAUL C. RINGGOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ULARE uling Address (Street and Number or i	E. MOONEY	City or Town	State 7in	Codel
						·
	20a. Method of Disposition 20b. Place of Dis	WILLARD AVENUE position (Name of	Date	20c. Location		
	I Dunai 2 Commation 3 Chemovarirom State		EMBER 14			
						MARYLAN
	23a. Part1. Enerthe some, or complications that caused the death. Do not a shock, or heart failure. List only one cause films. Immediate Cause (Final disease or condition resulting in death) a. FAILURE TO THRT Due to (or as a consequence of):		, CHESTER,	MARYL	AND 21	Approximate Interval Between Onset and Death
nysician/Medical Examiner	23a. Part1. Enter the schee, or complications that caused the death. Do not death shock, or heart failure. List only one cause in line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	106 SHAMROCK ROAD anter the mode of dying, such as card	, CHESTER,	, MARYL.	AND 21	Approximate Interval Between Onset and Death MONTHS YEARS
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 3 2007

DHMH 17 Rev 1/2001

Registrar

NOV 1 3 2007

		1 - State Registrar	Cert	tificate of	Death	R	eg. No.	2007	382	. J 4
Physicia	n	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day	Year	3. Time of D	
/Medic	al	RACHEL ANN LOGAN		4h City Tayya a	a Logation of Dooth	11	07	2007	1150	M
Examin	er	4a. Equility Name (If not institution, give street and number) COINSULA REGIONAL MEDICAL CE	nter	/ /	Location of Death		1	ounty of Death	ی	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)	9. Birth	place (State or	Foreign
Director		225-66-9837 ^{1□M 2} X ^F 80	Yrs.	Months Days	Hours Min.	01/26		VI	RGINIA	
and .		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Loc	ation					10d. Inside City	/ Limits
Maryla f sho ied at	ō								1 □Yes	
r 28a-	Director	10e. Street and Number	TLANTIC	10f. Zip Code		Ţ 1	I 0g. Citize	en of What Cou		X
ours after death with the Marylar rair, or Items 23a or 28a-f show Examiner must be notified at	a D	30751 WANDERING LN		2330	3		USA			
ier deat items :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	S. 13. W	/as Decedent of H Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14	4. Race - Ameri Black, White,		
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		□Yes 2 No	Specify:	, , , , , , ,	8	Specify: BL		
ified within 72 hours after death with the Maryland Hygiene. Hygiene, with than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		3 ▼ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a. Decede	ent's Usual Occup	pation			d of Business/In		
J within 72 ho giene. r than "natu the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	rind of work done O NOT use retired	during most of working	ng		3. 240000	addity	
d with giene green tha	E O	7	LAI	BORER			DC	MESTIC		
e d tal	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden S	urname)		
2 should be filled within and Mental Hygiene. Is marked other than aumatic event, the Me	ို	JOHN GRIFFIN			FANNI					
trai		19a. Informant's Name/Relationship (Type. Print) LINDA RILEY, DAUGHTER	1		and Number or Rura			Town, State, Zij) Code)	
a lea	- 10	20a. Method of Disposition 20b. Pl	ace of Dispos	ition (Name of	; D	VA 234		ation - City or To	own, State	
permit. Pages 1 Department of H Important: If ite any injury or ot		1 Aburial 2 Cremation 3 Hemoval from State		uatorý or other plac U.M. CE	í i	11/07	ΔΊΤ	ANTIC,	VΔ	
permit. P Departm Importar any inju	ŀ	21. Signature of Funeral Service Legensge		Name and Addre		11/07	ALL	интто,	V.D.	
B B E E		amuel 1. (DODS 1.	C	OOPER & I	HUMBLES FU	JNERAL (CO. A	ACCOMAC,	VA 2	3301
Medical		23a. Part I. Enter the disk a e, ir complete look that curved the death shock, or heart failure. List only one cylise on look hine.	. Do not ente	r the mode of dyir	ng, such as cardiac o	r respiratory arr	est,	Smit (Approximate Interval Betw	/een
Physician		Immediate Cause (Final disease or condition	Con	many	Ische my Dis	mia			Onset and De	eath
/Medical Examiner		resulting in death) Due to (or as a consequ	ence of):	16	λ	. = 68			-/	٠,
100	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	ence of):	Arce	my 010	case		-	Mron,	16
uted d ansit	Examine	Secuentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,		•					
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certificate be executed ding physician and see as the burial-transit	Medical	d								
leath certific attending p	Med	IF FEMALE:								
attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	death 3 □	Ectopic pregnancy Other (specify)	у		23	d. Date of deliv Month		ear
The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	eatn 5∐	Other (specify) _						
w requires that the d		Part II. Other significant conditions contributing to death but not resu	Iting in the und	derlying cause giv	en in Part I.	23e. Did to	bacco use	e contribute to t	he cause of de	ath?
quires in sign	od by	Endstage Renal Di	seas	e		1 □ Y	es 2□	No 3 ☐ Pro	oably 4 Ur	nknown
law re	Completed					24a. Was a		24b. Were auto	ppsy findings a	vailable
	E					autops perfor 1⊟ Yes	med2	death?	mpletion of cau 2□ No	ase or
Iclan: The	Be	25. Was case referred to medical examiner?			26. Place of Death					
Attending Physician: r death. ector: After this certific by the funeral director,	2		R/Outpatient		4 LI Norsing Hor				<i>[y)</i>	
ding l	<u>ö</u>	27. Manner of-Peath 28a. Date of Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	28b. Time of Injury	28c. Injur Wor M 1 □	ryat K? Yes 2 □ No	28d. Describe h	ow injury	occurred		
death death ctor; y the	ertification:	3 Suicide 6 Could not be 28e. Place of injury - At hor	me, farm, stre			28f. Location (S	treet and	Number or Run	al Route Numb	er.
al or / after I Dire d in b	je i	4 ☐ Homicide determined building, etc. (Specify)			City or Tow				,
	<u>ခ</u> ြ	29a. Certifier 1 Certifying Physician: To the best of my know	vledge, death	occurred at the tip	me, date and place, a	and due to the c	ause(s) a	ind manner as s	itated.	
the Hin 24 the Fi	Medical	(Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	and/or inve	esugation, in my o	punon, death occurr	eu at the time, c	ate and p	prace, and due t	o the cause(s)	
To To To	2	29b. Signature and title of/certifier		29c. Licens	e number	2	29d. Date	signed (Month,	Day, Year)	
	-	i un my man		200	16415 6		100	00 /.	200/	
6A 3		30. Name and address of person who completed cause of death (Item Michael Basnel 106	23a) (Type, P	Print) ARCOI	51, 54	115641	1 1	no		
Stat Registra	-	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examinat and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item Basue) 31. Date filed (Month, Day, Year) 32. Registrar's Signature and title of the person who completed cause of death (Item Basue) 31. Date filed (Month, Day, Year) 32. Registrar's Signature and title of the person who completed cause of death (Item Basue) 33. Registrar's Signature and title of the person who completed cause of death (Item Basue)	ure Apr	whe		•				
		110								

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				partment of Health and Mertificate of Death	ental Hygier	2007	38235
196	Physici /Medic		1. Decedent's Name (First, Middle, Last) Larry Sylvester Martin	1	2. Date of Death Month November	2 2 0 0 7	3. Time of Death 0235 M
	Examin Funeral		4a. Facility Name (If not institution, give street and number) 782 Jennie Dr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Severn Joint If Under 1 Year If Under 24 Hrs.		4c. County of Death Anne Ar	
L	Director		224-78-4293 1 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1 →		8. Date of Birth (Month, Day, Yes May 3 1.9	55 Vir	ginia
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Director	10a. State 10b. County 10c. City, Town or L		100	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
	with la or t be r				10g. (ariu y r
	eath ns 23 mus	era	782 Jennie Dr. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	USA 14. Race - Amer	ican Indian
036	ours after d al", or iten Examiner	by Funeral	1 Nover Married 37 Married 1 17/Ves 2 No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	
21215-0036	ithin 72 ho ne. nan "natur e Medical l	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	un Un	Kind of Business/N	ates
2	led w lygiel her tl nt, th	Š	12th Ö C	Custodian	(First, Middle, Maid	stal Se	rvice
Maryland	ges 1 and 2 should be f t of Heatth and Mental b If item 27 is marked ot or other traumatic evel	To Be	Ceolas Martin	Eturly	Mae Tar	pley	
<u>a</u>	d 2 sl th and 7 is r traur			ing Address (Street and Number or Rura			ip Code)
	Health Health tem 27		20a, Method of Disposition 20b, Place of Dispo	osition (Name of D	ern, Md.	Z 1 1 4 4 Location - City or 7	own. State
<u>o</u>	Pages nent of I int: If its iry or o		1 M Buriai 2 Deferration 3 Removal from State	ematory or other place) and Veteran 11-8		ownsvil	•
Baltimore,	permit. Pag Department Important: I any Injury o once.			Anname Reduces of Eacil Sons			re, Ma.
<u> </u>	a m e			321 West St. Ann			01
-	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Ela	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	Liver			22 mai 7/s
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts)				
oʻ	ate be executed hysician and the burial-transit	Examiner	resulting in death) Last c. Due to (or as a consequence of):				
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.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and wage 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	very Day Year
ecords, P	w requires that s been signed b should be deta	۵	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacc		the cause of death?
Υ		Completed			24a. Was an autopsy performed 1 Yes 2 X	prior to co	opsy findings available ompletion of cause of
Vital	ician; sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
	this ald	ရ	1 ☐ Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiel 27. Manger of Death 28a. Date of Injury 28b. Time of			6 ☐Other (Spec	ify)
0	iding Phys h. After this funeral dir	tion	Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	jury occurred	
DIVISION OF	Atten deat ctor y the	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)		8f. Location (Street City or Town, Sta	and Number or Rui ate)	al Route Number,
		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
)	To t with To t	Ž	29b. Signature and title of certifier Prayle Problem (u.c.)	29c. License number D27938 Print) Mospital Duve	29d. [Date signed (Month)	Day, Year) 5, 2007
4	10#		30. Name and address of person who completed cause of death (Item 23a) (Type, MOYEV GOV Sale AD 263	Mospital Duice	Glen Bo	idnie, ML	21061
	Sta Registra	ie ar	31. Date filed (Month, Day, Year) NOV 0 7 2007 32. Refistrar's Signature	Josefu			

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			1 - For State Registrar	State of Ma	aryland / [Depa <i>Cen</i>	rtment tificate	of He	ealth a Death	and M		giene (Reg. No.	007	38236
	Dhysisi	an	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Ruth P. Mellet	te							Nov.	6 ^{Day} 2	2007 ^{Year}	1:00 A M
	Examir	er	4a. Facility Name (If not institution, give s	street and number)			4b. City, T	fown, or l	ocation o	f Death		4c. Co	ounty of Death	
			Heritage Harbour					napo					ne Aru	
	Funeral Director		4/4-16-6083	7. Ag	e (In yrs. last bir 87	rthday) _ Yrs.	If Under 1 Months	Days	If Under 2 Hours	4.41	8. Date of Bir (Month, Pa Jan. 9	, 1920	9. Birth Cou Ida	place (State or Foreign ntry) NO
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loc	ation							10d. Inside City Limits
	Mary 4 she	jo	MD Prince G	oorgo!s	T T	nnar	Mar]	lboro	,					1 ☐ Yes 2X No
	28a	Director	10e. Street and Number	corge 5	0	pper	10f. Zip (10g. Citize	n of What Cou	ntry?
	h with		8863 Heathermore	Blvd.				207	772				USA	
	deat	Funeral		12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decede			gin? (Spe	ecify Yes or No Rican, etc.)	- 14	Race - Amer	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic avant, Ite Medical Evant if ar rural be routined at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2X1 If Yes, Give Year or Dates:	No		Yes, speci		Specify:	, ruento	nicari, etc.)		Black, White pec <i>ify:</i> Wh	ite
o O	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a.	Decede	ent's Usual	Occupat	ion	of worki	22	16b. Kind	of Business/Ir	ndustry
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and	be fi	Be	17. Father's Name (First, Middle, Last)					1			(First, Middle,	Maiden Su	лтате)	
Maryland	d Mer marka matic	Ţ	Lars Oscar Pea: 19a. Informant's Name/Relationship (Ty)	rson	405	A4 - 112	A 11	/01	Hann		ohnson			0.43
Ma	d 2 sl th an t7 is r traur		Camille Klinker /	-		-	David				Route Numbe		own, State, Zi _i S., MD.	21054
a,	lan Heal tam 2		20a. Method of Disposition	daugitter	20b. Place of	f Dispos	ition (Name	e of			ate		tion - City or T	
more,	ages ant of it: If if		1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	MD. Na	ry, cremi	atory or oth	her place)	1	11/1	2/2007			
alti	artme ortar injur		21. Signature of Funeral Service License	1	ויסוין. ועמן						11 Fune		Laurel,	FID.
ñ	Den Imp	ji.	Chum	Forwel	L		12 NV					e, MD.		15
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused	the death. Do							<u> </u>		Approximate Interval Between
	Pnysician _I		Immediate Cause (Final disease or condition	(Cerlin	C	An	V Ha	mil	> /				Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence	of):		1	, 01	1	cicle	Λ		
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as	a consequence	of):								
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8760	icate be executed physician and s the burial-transit			,	·	,								
89		edical												
Box	death certific e attending p d for use as l	M/U	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome		200						230	d. Date of deliv	ery
	0 0 0	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at	2 ☐ Fetal death time of death		Ectopic pre Other (spe						Month	Day Year
o.	at the de by the stached	hy	9 🗆 Unknown											
s,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	tributing to death b	ut not resulting ir	n the und	derlying ca	use given	in Part I.					he cause of death?
ecords,	w require been sign	eted									1	es 2 🗆 i	40 3 FIO	bably 4 Unknown
Rec	9 4 9	Completed									24a. Was autop perfo		24b. Were auto prior to co death?	opsy findings available impletion of cause of
_	i cian: Th certificate rector, pag	e Co	25. Was case referred to medical	-						100	1 ☐ Yes	2 J No	1 Yes	32 No
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Ö	g Phy er this eral c	$\vdash $	27. Manner of Death	28a. Date of Injur	y. 28b. 1	Time of		c. Injury a	at		8d. Describe			y)
0	ttanding F death. ctor; After y the funer	atlo	✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(fear) II	njury	М	Work? 1 □ Ye	s 2 🗆 N	10				
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ury - At home, fa	ırm, stree	et, factory,	office		2	28f. Location (S City or Tox		Number or Run	al Route Number,
	ital o		- 71/											
	To tha Hospital or , within 24 hours after To the Funaral Dire completely filled in E	Medical	29a. Certifier (Check only one) Certifying Physical Examination	ician: To the best of ler: On the basis of and manner sta	examination and	e, death o d/or inve	occurred at estigation, i	t the time in my opir	, date and nion, death	i place, a h occurre	ind due to the ed at the time,	cause(s) an date and pla	ed manner as s ace, and due t	stated. o the cause(s)
	To tha within 2 To the complet	Ž	29b. Signal free and title of certifier				29c.	License r	number			29d. Date s	igned (Month,	Day, Year)
								DE	707	28		1)	-06-0	77
Ì	10)		30. Name and address of person who con	mpleted cause of d	eath (Item 23a) ((Type, P	rint)							
			Atitya Chopra 1	IVI. D. 60	XX Kic	clope	A pl	rve.	# 23	1 1	nnak	silos	am,	21401
n.	Sta Registra		31. Date filed (Month, Day, Yèar) NOV 0 7 2007	32. Registra	on s signatura	1)	9							

State of Maryland / Department of Health and Mental Hygiene Reg. No ZUU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day James Alphonso Nolan 2007 November 7:10P 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3110 Bellbrook Court Temple Hills Prince George If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, May 3, 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□F Director 316-68-6508 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3110 Bellbrook Court 20748 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ñ Yes 2 □ No 1965-If Yes, Give Year or Dates: 1967 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 □ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Dept. of Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Francis ၉ Nolan Marie Stevens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude A. Nolan/Wife 3110 Bellbrook Court Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11/13/2007 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Md. 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature d uneral Service dcens a 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Prostate Cancer disease or condition resulting in death) 3 yrs. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and if be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Anemia 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Malnutrition 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perform 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 🕱 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0060050 11/5/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mahrukh Hussain, M.D. 1221 Mercantile Lane Largo, Md. 20774

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For 1 _ State	State of Ma	iryland /		ırtment of H <i>tificate of l</i>				_		00000
	-		Registrar 1. Decedent's Name (First, Middle, Las	it)		Cei	inicate of t	Deau		2. Date of De	Reg. No ath	2007	3. Time of Death
	Physicia /Medic		Roger Carl Ohlr						1	Month Novemb	er 1	y Year 2007	4:58 P ^M
i i	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	r Location				. County of Death	
			5321 Allandale Ros		e (In yrs. last b	hirthday)	Bethesda If Under 1 Year		er 24 Hrs. 8	3. Date of Birl		ntgomery	ace (State or Foreign
	Funeral Director			X M 2□F	69	Vrc	Months Days	Hours	Min.	(Month, Da	y, Year)	938 Ohio	try)
	ъ		Usual Residence of Decedent				- tion			Dept 1	<i>J</i> , 1		Od Jasida City Limita
	farylar show ed at	o	10a. State 10b. County Maryland Montgome:	^37	10c. City, To Bethe		cation						0d. Inside City Limits 1 ☐ Yes 21 No
	the N 28a-1 notifi	Directo	10e. Street and Number	- y	Deche	Jua	10f. Zip Code				10g. Cit	tizen of What Coun	try?
	th with 23a or ist be		5321 Allandale Roa	ad			20816				USA		
36	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 【X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba I ☐ Yes 2☐XNo	ispanic O an, Mexica Specify		ify Yes or No ican, etc.)	-	14. Race - Americ Black, White, Specify: Whit	etc.
5-0036	2 hour atural cal Ex	ted t	15. Decedent's Ed	lucation			lent's Usual Occup				16b. K	ind of Business/Inc	
21215	thin 7: e. an "n	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	(Give life, L	kind of work done of OO NOT use retired	during ma d)	st of working	7			
7	led wi lygien her th nt, the		47 Febbode Name / First Middle Look	5+	A	ttor	ney	10 Moth	hor's Nome (First, Middle.		Practice	2
and	0 = 0 2) Be	17. Father's Name (First, Middle, Last) Carl John Ohlrich							riisi, middie, s Noss		i Surname)	
Maryland	2 should be n and Mental is marked raumatic ev	٩	19a. Informant's Name/Relationship (Type. Print)	19	9b. Mailir						or Town, State, Zip	Code)
	and 2 ealth a n 27 is		Grace E. Ohlrich/v	vife ————————————————————————————————————			Allandale	Rd.					
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	ceme	tery, crer	sition (Name of natory or other place		Da			ocation - City or To	
Ē	it. Paritmen intant: injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		Chesa		ke Cremat					tsville,	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic e once.	4	Bever Lo	alth	MO125	$1 \mid B$	everly L.	Hec	krotte	P.A	. C1	P.O. Box arksville	. MD 21029
1	Physician		23a. Part1. Enter the deease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	ie.		er the mode of dyin	_				ic .	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):	U		,				/
3		Jer.	Sequentially list conditions, if any, leading to transculate	b. Due to (or as a	a consequenc	8 of).							
	cuted nd ransit	Examiner	if any, leading to trim legiste cause. Enter Underlying Cause (Disease or injury that initiated events	C									
60,	be exectan a		resulting in death) Last	Due to (or as	a consequenc	e of):							
68760,	physics the t	edical		d									
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)	/				23d. Date of delive Month	ery Day Year
<u>Ч</u>	at the i by th stache	Phys	9 Unknown							00- Dist			
ords,	equires the		Part II. Other significant conditions of Diabetes mellitu	•		,	denying cause givi	en in Pan		1 🗆		use contribute to the	ably 4 □Unknown
Vital Records,	sician: The law certificate has b irector, page 2 sf	Completed by								24a. Was auto perfo 1∐ Yes		prior to con death?	psy findings available npletion of cause of 2 No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			• acipoa Othe	OF:		Check only o			
0	g Phys er this eral dir	n: To	1 ☐ Yes 2X No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/0	Outpatier Time of Injury	I 3 DOA	4 LJ r		e 5 X Resi 3d. Describe		6 ☐Other (Specifing occurred)	v)
ion	ending Fath. or: After he funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		(rear)	Injury		Yes 2	□No				
Division or	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju- building, etc		farm, str	eet, factory, office		28	Bf. Location (City or To	Street ai wn, State	nd Number or Rura e)	I Route Number,
	e Hospit 24 hour e Funera letely fille	Medical (ysiclan: To the best of niner: On the basis of and manner sta	examination								
	To th withir To th comp	Me	29b. Signature and title of certifier	_/			29c. Licens	e number	-			ate signed (Month,	
			1 4/00	1	> _	>	104	29	79		No	evember	12,2007
3	000		30. Name and address of person who						2.11		110	2/2 2:	
	Sta	te	Michael A. Card 31. Date filed (Month, Day, Year)	32 Rodetr	ar's Signature			ch,	W4 (1)	more d	40.	21231	
	Registr	_	NOV 1 4	2007 Maria	ties . I	4	South 1						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3, Month Louis Michael Phillips, III 2007 3:38 A November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3/9/1943 Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 ☐ F South Carolina 64 408-70-4939 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 Tyes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1809 Millridge Ct. 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Affiled Follows 1 X Yes 2 □ No If Yes, Give Year or Dates: 1963–66 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Business Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis M. Phillips, Jr. Margaret Frances Nolen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marina D'Almeida-Rowley/Companion 1809 Millridge Ct., Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Kalas Crematory 11-6-07 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Will 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lyen disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Every the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ye wa 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 1 → Natural 2 → Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760. Division or Vital Records, P.O.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Marylan Heath and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show The traumatic event, the Medical Examiner must be notified at

of Health item 27 i

permit. Pages 1
Department of He
Important: If iten
any Injury or oth

Physician

Baltimore, Maryland 21215-0036

Examiner Physician/Medical signed by the a ģ Completed certificate has birector, page 2 s Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific telly filled in by the funeral director, Be Certification: To

(Month, Day

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Apropelis Md 2140,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier 41)

6 ☐ Could not be

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peterson 05011 MID 31. Date filed (Month, Day, Year)

NOV 0 9 2007

32. Registrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

within 24 hours a

the

Registrar

State

10 CENTER DRIVE, BETHESDA, MD 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

SHENOM

31. Date filed (Month, Day, Year NINV 0 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra Amebd#5. PerFam. PGC11-13-07cr Certificate of Death 38211 Reg. No. 2007

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	Physicia	an	Decedent's Name (First, Middle, L						November 1		ar	
	/Medic		Shirley	Mae F	Peters				November .	1, 2007	11:45 P M	
	Examin	er	4a. Facility Name (If not institution, g	ive street and number)		4b	o. City, Town, o	r Location of Death		4c. County of D	eath	
			Charles County Nursi	ing & Rehab. Cer	nter		LaP1a	ta		Char1	es	
	Funeral		5. Social Security Number 6. 578-24-1465	Sex 7. Age (/	In yrs. last b 32	M	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 2	Year) 9.	Birthplace (State or Foreign	
	Director		· 578 24 3400	1 □ M 2 🔀 F) <u>.</u>	Yrs.	0.00]	January 25	5, 1925	Country) Washington, DC	
	<u>D</u>		Usual Residence of Decedent									
	rylan how at	١.	10a. State 10b. County	10	0c. City, Tov	wn or Location	on				10d. Inside City Limits	
	Ma Fled	Ş	Maryland Charles		Waldo	rf					1 □ Yes 2/12/15/0	
	r 288	ire	10e. Street and Number			1	10f. Zip Code		10	g. Citizen of What	Country?	
	3a o	0	70 Village Street			İ	20602			USA		
	ns 2	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		merican Indian,	
	fter of liner	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces? XX Yes 2 □ No	1945-	If Y∈	es, specify Cuba	an, Mexican, Puerto	Rićan, etc.)	Black, W	hite, etc.	
2	ırs al	þ	3 Widowed 4 □ Divorced	If Ves Give	1946	1 🗆	Yes 2 XNo	Specify:		Specify:	White	
ş	tura sal E	ed	15. Decedent's	Education	16	a. Decedent	's Usual Occup	pation	1	6b. Kind of Busine	ess/Industry	
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	with ene. thai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			et Analys			Federal Gov	emment	
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0	2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be c	Robert C. Hoo	1				Juan:	ita V. Ba	ailev		
	d Me d Me mark mati	<u>٢</u>	19a. Informant's Name/Relationship	(Time Print)	10	h Mailing A	ddross (Stroot	and Number or Rur			a Zin Cada)	
2	12s han 7 Isr		Yvette Taylor / Siste					Road Waldon			e, zip code)	
<u>-</u>	l and dealt		20a. Method of Disposition							nd 20601 20c. Location - City	or Town State	
5	ges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifled at		1 ☑ Burial 2 ☐ Cremation 3				on (Name of ory or other place			•		
	. Pa tmen tant: jury		4 □ Donation 5 □ Other (Spec	J	Cedar I	Hill Ce		11/06/		Suitland,		
0	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trai		21. Signature of Funeral Service Lic	ensee			ame and Addre			alas Funera		
_	20 E 20		My F. K.	ale to				ill Road Oxo		-	0745	
			23a. Part1. Effter the disease, of co shock, or heart failure. List on	mplications that caused the	e death. Do	not enter th	he mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	1- 1			nd h			Onset and Death		
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	urted number	Examiner	Cause (Disease or injury									
6	al-tra	ха	resulting in death) Last	c. Due to (or as a c	onsequence	e of):						
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<	ding se as	/Me	IF FEMALE:	23c. If yes, outcome pf	nregnancy					004 D-44	4-15	
ב ב	atten atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 [Fetal dea			у		23d. Date of Month	,	
;	he de	/sic	1 ☐ Yes 29 █ No 9 ☐ Unknown	4∐Pregnant at tirr 9∐Unknown	ne or death	5 LI Ot	ther (specify) _					
	d by	Physici	Part II. Other significant conditions	contributing to dooth but r	not requiting	in the under	rhvina onuos siv	on in Dart I	220 Did tob	anna una contribut	e to the cause of death?	
Ď	es the	þ		_	_				1			
2	equir en s ould	ed	Diabetes m	ellitus, 1	ryper	terim	hype	er jip. Ima	1 □ Ye	s 2 No 3	Probably 4 Unknown	
נ	law ras be	ple	atrial pipor	1/ution . A	3/2mi	u,			24a. Was an	24b. Were	e autopsy findings available to completion of cause of	
	The te had age	Completed							autopsy perform 1⊟ Yes 2	ned? deat	h? Yes 2 □ No	
2	an: tifica tor, p		25. Was case referred to medical					26 Place of Deat	h (Check only one		169 2 110	
>	s cer lirect	o Be	examiner? 1₁ 万 4_Yes 2 No	Hospital: 1 ☐ Inpatient	2□ FR/C	Outpatient :	3 DOA Oth	or:		nce 6 🗆 Other (5	Proposition .	
5	Phy er this	- To	27. Manner of Death	28a. Date of Injury		. Time of	28c. Injui Wor	-	28d. Describe ho	w injury occurred		
5	ding h. Afte fune	ţio	1 ☐ Natural 5 ☐ Pending 2 ☑ Accident investigation	ion (Month, Day Y	'ear)	Injury	M 1	rk? Yes 2.K∑No	fell in	in the bathroom		
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2	or A after Dire in b	Certification:	4 ☐ Homicide determine	building, etc. (Specify) <	Sunsti	we ASSIS	ting winning	City or Town,	reet and Number or Rural Route Number, state) 70 V ((g s f s f 1 M) 20602		
	pital ours a eral filled		29a. Certifier 1 CertifyIng 1	Physician: To the hest of	my knowled	ge death or	curred at the ti	mo, date and place				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Physician: To the best of r aminer: On the basis of examiner states	xamination a							
	thin the thi	Med	29b. Signature and title of certifier	and manner state	u.		29c. Licens	se number	20	d. Date signed (M	onth Day Year)	
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18	(141)		30. Name and address of person what 11655 Wines	o completed cause of deat	th (Item 23a) (Type, Prin	nt) You I'm	ZHGOG	, KI, M?	Li		
fi	/		1(655 Wines 31. Date filed (Month, Day, Year) NOV 0 7 2007	~ P PC L	-a P	wa	Just	60646				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	de						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hilda Julia Royall 10, 2007 10:45 AM November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Manor Care Health Care Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖺 F 88 578-44-2865 09/04/1919 Director Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 AYes 2 No Director DC N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 718 Park Road, N.W. Apt. #1 20010 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: African American Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If item 27 is marked other that any injury or other traumatic event, the Agnee. House Keeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Douglas Royall Rose Jefferson ٩ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 Ouebec Street NaW., Apt. #119 Washington, D.C. 20008 19a. Informant's Name/Relationship (Type. Print) Carmencita Smythe/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Belmead Cemetery 11/16/2007 Powhatan, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 7400 Georgia Avenue, N.W. Washington, D.c. 20012 21. Signature of Funeral Service Licens Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy this certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Z No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier soo, mo 00057124

Registrar DHMH 17 Rev 1/2001

State

Box 68760

9715 Medical Center Drive, Suite#201 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Dr. Truong Bao

31. Date filed (Month, Day, Year)

NOV 14

			1 - For State Registrar	State of Ma	iryiand / Dep <i>Ce</i>	ertificate of		vientai Hy	glene Reg. No. 2 (07	3824
	Physic	an	1. Decedent's Name (First, Middle, La Joseph G. Strieg					2. Date of De Month	Day ber 3, 2	Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give 860 Generals High	e street and number)			or Location of Death	1	4c. County	of Death	10:14p ™ Arundel
B 70 t	Funeral Director		213-07-7441	Sex 7. Age	e (In yrs. last birthday 91 Yrs.) If Under 1 Yea Months Days		8. Date of Bir (Month, Di Oct. 3	0,1916	9. Birthp Coun Ma	place (State or Foreign oryland
1000	ne Maryland 8a-f show ptified at	ector	Usual Residence of Decedent 10a. State 10b. County FL St. I	Lucie	10c. City, Town or L	ocation					0d. Inside City Limits 1
	a or 2	1 Dire	10e. Street and Number 1205 SW Bent Pine	e Cove		10f. Zip Code	4986		10g. Citizen of	What Coun USA	itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ever in U.S. 13		Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White,	
21215-0036	within 72 ho iene. • than "natu the Mecical	Completed by	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	(Giv	edent's Usual Occi e kind of work don DO NOT use retir Engine	e during most of wor red)	king	16b. Kind of B		dustry 1road
Maryland 2	uld be filed Mental Hyg srked other stic event, i	To Be C	17. Father's Name (First, Middle, Last, John M. Striege)				18. Mother's Nam	ne (First, Middle Kormann	h, Maiden Surnar	ne)	
, Mar)	and 2 sho ealth and I n 27 Is ma er trauma		19a. Informant's Name/Relationship (Joseph R. Striege		173	3 River B		n, City or Town, State, Zip Code) , MD 21409			
Baltimore,	. Pages 1 Iment of H tant: If Iter Jury or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)		20b. Place of Disp cemetery, cri Meadowri		20	7. 8, 007	20c. Location Elkri	,	
Bal	permit Depar Impor any In		21. Signature of Funeral Service Licer	Alla			Ritchie F			ark F ark,	uneral Hom MD 21146
	Physician /Medical		23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cere	brovascu	1547.5	173107 175435	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Atria	a consequence of): For 10 a consequence of).	ation					7 days
68760,	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	a consequence of):						
.O. Box	ath cer	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan	cy			ate of delive	ery Day Year
Δ.	quires that the de n signed by the a uld be detached t		Part II. Other significant conditions of	contributing to death bu		underlying cause g	iven in Part I.	23e. Did			ne cause of death?
Records,		Completed by	Hyperknsion)		181.1			psy ormed?/	Were autoprior to condeath?	psy findings available mpletion of cause of 2 □ No
Vital	Physiclan: The la r this certificate had ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea	th (Check only	one)	Dai	ughter's
o	aling 1. After funer	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 2 ER/Outpatient 2 ER/Outpatient 2 Injury	of 28c. Inj	ther: 4 □ Nursing Hury at ork? □ Yes 2 □ No	ome 5 ☐ Res 28d. Describe	idence 6 😡 Oth	ner <i>(Specif</i>) red	7 TOETICE
DIVISI	# TO 75 -	Certification:	3 Suicide 6 Could not be determined	e 290 Place of inju	ry - At home, farm, s . <i>(Specify)</i>			28f. Location (City or To	Street and Numi wn, State)	ber or Rura	I Route Number,
	e Hospital or A 124 hours after e Funeral Direc letely filled in by	dical C	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exar	nysician: To the best of miner: On the basis of and manner star	examination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occu	, and due to the	cause(s) and m , date and place,	anner as st	ated. the cause(s)

State Registrar

NOV 0 7 2007

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8096 D Edwin Raynor Blvd. Pasadem, MD 21122

29c. License number

29d. Date signed (Month, Day, Year)

November 6, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 3, 2007 **Physician** Nora Lee Scaffe 11:35a [™] /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Severna Park Anne Arundel 481 Retford Drive If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Mar 9 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Year 918 Months 1 □ M 2 🗙 F 89 266-07-6035 Mississippi Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County "natural", or items 23a or 28a-f show edica Ex-miner must be notified at 1 ☐Yes 2 🙀 No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7843 Americana Circle 21060 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married White Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 11 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any In]ury or other traumatic event, i 17. Father's Name (First, Middle, Last)
Earlie Allen 18. Mother's Name (First, Middle, Maiden Surname) Eva Fitzgerald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severna Park, MD 21146 Norman Scaffe/Son 481 Retford Drive Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 7, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signalure of Funeral Serve e license 22. Name and Address of Facility Severna Park Funeral H Severna Park, MD 21146 Barranco & Sons, P.A. 495 Ritchie Hwy. 2 - art1. Enter the disease, or committations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Couse (Final disease or ondition resulting in death) **Physician** Biliary Duct Cancer 1 Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Detail death 1 ☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the aid be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 4 □Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform No 1∐ Yes Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျ this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: 27. Manner of Death spital or Attending P nours after death. meral Director; After I y filled in by the funera After (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifier

State Registrar

31. Date filed (Month, Day, Year) NOV 0 7 2007

30. Name and address of person who completed

2003 Medical Parkway Suite 100 Annapolic

of death (Item 23a) (Type, Print)

D35259

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JOHN H. STURGE 2007 11 04 0400 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F 78 Director 215-96-7870 09/17/1929 GUIANA. S.A. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at MD HOWARD COLUMBIA 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or Items 23a or event, the Medical Examiner must be re-6700 BUSHRANGER PATH 21046 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH SECURITY OFFICER filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filk tment of Health and Mental Hi tant: If Item 27 is marked oth Be WILLIAM STURGE ANNETTE BLAKENY ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGAN. STURGE/SON 6700 BUSHRANGER PATH COLUMBIA, MD 21046 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State LINCOLN MEMORIAL 11/10/07 4 ☐ Donation 5 ☐ Other (Specify) SUITLAND, MD 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 50 DSIS /Medical Due to (or as a consequence of): Examiner heumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Ke physician and the burial-transit death certificate be executed Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ρ Day 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 ☐ Unknown as theen signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed certificate Division or Vital 1☐ Yes 2☐No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ne 1 ☐ Inpatient ဥ 2 ER/Outpatient 3 DOA After this 27. Manne Teath To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Linatural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🚅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

AHMINA 31. Date filed (Month, Day, Year) NOV 0 7 2007

29b. Signature and title of certifier

AHMED 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Silver

D0060100

831 University x Spring MO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:30 am Donald E. Smith November 2007 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□ F Director September 18,1930 District of Columbia 578-42-5388 Usual Residence of Decedent ishow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 K No Director Maryland Prince George's Adelphi 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Item 27 is marked other than "natural", or items 23a or other traumatic event, the M-di-al Examiner must be re U.S.A. 7300 16th Place 20783 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1948-1949 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. s marked other than College (1-4or 5+) Personnel Clerk Department of Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental H f item 27 is marked oth Be Edna Thomas 2 John Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16th Place, Adelphi, Maryland 20783 Kathryn Smith - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o þ 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 11/16/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Horosetersh /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 201 1 ☐ Lapatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospital
within 24 hours a
To the Funeral Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-12-07 00060100

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 4 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMED, MD

forte

BLVD

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

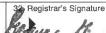
Physician: The law requires that the death certificate be executed Hospital or Attending hours after death uneral Director: filled in by the hin 24 hours a

31. Date filed (Month, Day, Year) State 1 4 2007 Registrar

29b. Signature and title of certifier

James P. Richardson, MD

29a. Certifier (Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



0

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D27394

3333 N. Calvert Street, #325, Baltimore, MD 21218

29d. Date signed (Month, Day, Year)

November 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December 12, 2001 September 12, 2001				1 - For State Registrar	State of Marylan	•		of Health of Deat		_	giene Reg. No. 20	07 3824	(
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21. Signature of Furners Service Licenses 22. Signature of Furners Services 23. Part Letter the disease, or completation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. Physician Medical Examiner 23. Part Letter the disease, or completation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. 23. Part Letter the disease, or completation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. 23. Part Letter the disease, or completation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. 23. Part Letter the disease, or completation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. ACM Part Letter the disease, or completation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease, or completation that caused the death. ACM Part Letter the disease or completation that caused the death. ACM Part Letter the disease or completation that caused the death. ACM Part Letter the disease or completation that caused the death. ACM Part Letter the disease or completation that caused the death. ACM Part Letter the disease or completation that caused the death. ACM Part Letter the disease or completation that caused the death. ACM Part Letter the disease or completation that caused the death. ACM Part	ou ⊷	20===		·	Removal from State	emetery, crer	natory`or oth	er place)	VOZ		20c. Location -	City or Town, State		
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State Registrar 31. Date filed (Month, Day, Year) 32. Administrar's Signature				N. K. K. K. C.		100	0 1 []	CC 1	1000	- cui,	our	9,19000000	E	

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physiclan: after death death

Baltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) and manner stated. 29b. Signature and title of certifier

determined

29c. License number D333 LZ

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOLLAND, MD NATIONAL INSTITUTES OF HEALTH, 10 CENTER DR. BETHESDA, MD STEVEN M. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

NOV 0 7 2007

3□ Suicide

29a. Certifier

4 ☐ Homicide

DHMH 17 Rev 1/2001

State

Registrar

filled in by

within 24 hours a

To the Funeral I To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mar	-	epartment of h		Mental Hy	giene			
			State Registrar			Certificate of	Death		Reg. No. 2	0.07	38252	
Physi	ioia	n c	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath Day	Year	3. 4 mb of Death	
Physic /Med		_	HAZEL	V. THOMAS	5			NOVEMB	-	007	9:45 A M	
Exam	nine	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1	4c. Cour	nty of Death		
			5603 CARTERS L		//	RIVERD		Dotte of Die			ORGE 'S	
Funera			5. Social Security Number 6. S	DM 2015	(In yrs. last birt	Yrs. Months Days	Hours Min.	8. Date of Birt	y, Year)	Coun		
Directo	or	-	577-22-6053 Usual Residence of Decedent	89	,			DEC 3	1917	MARY	LAND	
tural", or items 23a or 28a-f show al Examiner must be notified at			10a. State 10b. County	1	0c. City, Town	or Location				1	0d. Inside City Limits	
-f sh	.	ţ	MD PRINCE	GEORGE'S	RIVE	RDALE					1X Yes 2 No	
r 28a noti		Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	itry?	
3a o st be		<u>=</u>	5603 CARTERS LAN	E		207	37			USA		
r mu		Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		ace - Americ		
ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ı	E	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅 No		1 ☐ Yes 2X No		o Filoan, etc.)	ŀ	cify: BLA		
ıral"; Exa		d by	3 MWidowed 4 ☐ Divorced	Year or Dates:								
"natı		Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of wor	king	16b. Kind of	Business/Ind	dustry	
han e Me	- 1	d I	Elementary/Secondary (0-12)	College (1-4or 5+)			<i>a)</i>		DDTIL	4 mm		
Hygie other 1 ent, th			12th 17. Father's Name (<i>First, Middle, Last</i>)			COOK	18. Mother's Nam	ne (First Middle	PRIVA			
dental F rked of tic eve	- 1	Be	ESSIE SIMMS				PINKEY			arrie)		
and Menta is marked raumatic ev	- 1	၉ .	19a. Informant's Name/Relationship (Time Print)	106	. Mailing Address (Street				un Stata Zin	Code	
Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic erongs.			MERRILL THOMAS		i i	-	COURT ELD				,	
of Health a Item 27 is other trai			20a. Method of Disposition		20b. Place of	Disposition (Name of	;	Date	20c. Location			
nent of H int: If Ite iry or ot			1 🖾 Burial 2 ☐ Cremation 3 ☐		cemeter	ry, crematory or other pla	i i			•		
rtant njury		-	4 Donation 5 Other (Specify	<u> </u>	CHURC	H CEMETERY 22. Name and Addre		0/2007	PRINCE	FREDE	RICK, MARYI	
Depa mpo any i	once.		21. Signature of Funeral Service Licer	10010h					JENKINS FUNERAL HOME ANDOVER, MARYLAND 20785			
ry and			23a. Part1. Enter the disease, or com	plications that caused th	ne death. Doin					KILAND	Approximate	
			shock, or heart failure. List only	one cause on each line.			ng, ocom do ocimico	or roopiratory at	1001,		Interval Between Onset and Death	
ıysiciar Medica			Immediate Cause (Final disease or condition resulting in death) HYPERTENSION									
kamine			Due to (or as a consequence of): DIABETES MELLITUS									
	6	-	Sequentially list conditions D									
nsit		n n	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c CARDIAC ARRHYTHMIA									
physician and the burial-transit	1.	Examiner	that initiated events resulting in death) Last CARDIAC ARRITITIFIES C. Due to (or as a consequence of):									
physician and s the burial-transit	- 18	dical										
phy.	:	edic		-d.								
y the attending p		Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf					23d. I	Date of delive	ery	
atte d for	:	cia	in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							Month	Day Year	
ned by the a		hysi	9 Unknown	9□Unknown								
ned b			Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause gi	ven in Part I.	23e. Did to	obacco use co	ontribute to th	ne cause of death?	
been signe should be	:	g p	ALZHEIMER'S DI	SEASE				1 🗆 1	Yes 2₹ No	3 □ Prob	pably 4 ☐ Unknown	
shou		Completed by						24a. Was	an 24	b. Were auto	psy findings available	
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ificati or, pa		ပိ	25. Was case referred to medical				26. Place of Dea	1 Yes	2K No	1 ☐ Yes	2 2 No	
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al this	1	⊢ ⊦	27. Manner of Death	28a. Date of Injury	28b. T	Time of 28c. Inju		28d. Describe I			y /	
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r death. ector: After this certific by the funeral director,	:	tipem	3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)									
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Physician

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

•	#	siciar edica imine	
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Division or Vital Records, P.O.

Medical Certification: To Be Completed by Physician/Medical Examiner

Pleas	se Type or Pri					_	_	ble.	
for State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of I <i>rtificate of</i>		d M	, ,	ene g. No. 2 ()	0.7	20253
1. Decedent's Name (First, Middle	e, Last)					2. Date of Death	20	V	3. Time of Death
WILLIAM EDWARD	TOWNSEND, JE	L				November	Day 12 2	Year CO7	10.55AM
4a. Facility Name (If not institution MEMORIAL	, give street and number) HOSPITAL		4b. City, Town, o		eath		4c. County	of Death	
5. Social Security Number		e (In vrs. last birthday)	EAS'T		Hrs.	8. Date of Birth			ce (State or Foreign
219–12–4233 Usual Residence of Decedent	1 X M 2□F	82 Yrs.	Months Days	Hours N	Min.	(Month, Day, DECEMBER		Country	
10a. State 10b. County MARYLAND OUEEN	ANNE'S	10c. City, Town or Lo						10d	Inside City Limits 1 ☐ Yes 2 📉No
10e. Street and Number		DILIVERDY	10f. Zip Code			10	g. Citizen of \	What Country	/?
107 CONGRESSION	AL DRIVE		2166	6		1	UNITED	STATES	S
11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, P	? (Spe uerto F	cify Yes or No- Rican, etc.)		e - American ck, White, etc	
1 □ Never Married 2 📉 Marri 3 □ Widowed 4 □ Divorced	Year or Dates:	942-1945	1 ☐ Yes 2 🛣 No				,,,,,	WHIT	
15. Decedent (Specify only highes		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	workin	g 1	6b. Kind of Bu	usiness/Indu	stry
Elementary/Secondary (0-12)	College (1-4or 5	+)	NAL SALES		ER	M	ANUFAC	TURING	
17. Father's Name (First, Middle,	Ė					(First, Middle, M	laiden Surnan	ne)	
WILLIAM EDWARD 19a. Informant's Name/Relationsh		10h Mailir	ng Address (Street			. LEEDS	City of Town	State Zin C	ada)
SHIRLEY TOWNSEN	_								·
20a. Method of Disposition	•	20b. Place of Dispo	ONGRESSIO esition (Name of matory or other pla	i	D:	ate 2	NSVILLE Oc. Location -		
1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (<i>S</i>)		CHESAPEAK		1.0	200	BER 13 S	TEVENS	VTI.E.	MARYLAND
21. Signature of Funeral Service	Licenson	FE.	2. Name and Addre	ess of Facility ELFENBE	IN	AND NEW	NAM FUN	IERAL I	HOME, P.A.
23a. Parti. Enter the disease, or shock, or hear failine. List	complications that caused		06 SHAMRO ter the mode of dyi					Δ.	oproximate
Immediate Cause (Final	only one cause on each li		CARDIA						nterval Between Onset and Death
disease or condition resulting in death)	a.	a consequence of):	CHRUIA	_ 414	- 	cc 1 join		-	TOURS
Sequentially list conditions,	b								
cause. Enter Underlying	Due to (or as	a consequence of							
Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
	Due to (or as	a consequence ory.							
	d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnanc Other <i>(specify)</i>	y y				te of delivery onth D	ay Year
9 ☐ Unknown Part II. Other significant conditio	ins contributing to death b	it not resulting in the iii	nderlying cause giv	ven in Part I		23e Did tob	acco use cont	ribute to the	cause of death?
HYPERTE	NSION			ven in Fait i.	_		s 2 No		
AORTIC	ANEURYS	\sim		·	_	24a. Was an autopsy perform	/	Were autops prior to comp death?	y findings available detion of cause of
25. Was case referred to medical				26 Plana of	Death		No No	1∐Yes 2	□ No
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2/2/ÉR/Outpatier	nt 3 DOA Oth	oor:		ne 5 ☐ Reside		er (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	f 28c. Inju		1	8d. Describe how			
2 ☐ Accident investig	ation			Yes 2 □ No					
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		iry - At home, farm, str c. (Specify)	eet, factory, office		2	8f. Location (Str. City or Town,	eet and Numb State)	er or Rural F	Route Number,
29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical i	g Physician: To the best Examiner: On the basis o and manner sta	examination and/or in	h occurred at the ti vestigation, in my	ime, date and p opinion, death o	olace, a	nd due to the ca	use(s) and ma ate and place,	anner as stat and due to t	ed. he cause(s)
29b. Signature and title of certifier			29c. Licens	se number 6641	+1		d. Date signe		2007
30. Name and address of person of ROLLI RAMESH	t 2195 W	ASHINGTON		r EAG	STO	N MI	D 2	1601	
31. Date filed (Month, Day, Year) NOV 1	3 2007 32. Registr	ar's Signature	parti						

State

Registrar

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Metrius 2007 Loronzo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anndel Medical Cent +nnapolis Anne Arundel tnne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 M 2 F NA Mary land Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Md nne Arunde 1 ☐ Yes 2 No Director asadena 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21122 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 100 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warden Shawn Lorenzo Nicole rusbutl riana ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valler Pasadena, 21122 mother Briana Hudson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2√Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 11/5/2007 Baltimore, MD 21. Signature of Sungral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-trar the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by teneral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? After this certificate 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

NOV 0 7 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

10/30/2007

State of Maryland / Department of Health and Mental Hygien [] 1 - State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:45 P M Floyd Peter Weincek November 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Heritage Harbour Health & Rehab. Ctr. Anne Arundel Annapolis 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 327-16-1717 9/25/1919 Illinois Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rthan "natural", or Itema 23a or 28a-f ahov tre Medical Examiner must be notified at 1 Yes 2 No Director Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 410 Hamlet Club Drive 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. MYes 2 □ No Yes, Give 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by r yes, Give Year or Dates: 1943–46 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if itam 27 is marked other than any injury or other traumatic event, if a Medical Once. Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Medical year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James S. Wiencek 2 Maryann Labedz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine P. Weincek/ Wife 410 Hamlet Club Dr., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 11/6/07 Edgewater, MD 21. Signature J. Fundra Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): Examiner eldiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ettending physicien a for use as the burial Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No autopsy performed's 2 NO 25. Was case referred to medical 26. Place of Peath Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 atural 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) >5707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditia Chopra
31. Date filed (Month, Day, Year) Aditya Ridgel #231 600

DHMH 17 Rev 1/2001

State

Registrar

32. Redistrar's Signature

NOV 0 7 2007

Examiner certificate be executed burial-trar Box 68760, attending physician for use as the buria Records, P.O. detached þ signed t peen has page 2 certificate or Vital Physician: this

Division

Maryland 21215-0036

3altimore,

5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

29c. License number

State

Certification:

Medical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year)

NOV 0 7 2007

Name and address of person who completed cause of death (Item 23a) Type, Print)

11 CHAR J. La FENTA WY YYY DEFENSE HIGHWAY ANNAPOUS MOZIYU) Figistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04^{Day} Physician LATHEN WILLIAMS Month 2007ar 5:24 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 XM 2 ☐ F 248-46-1554 06/01/1933 GREENVILLE, Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits PRINCE GEORGES 1 X Yes 2 □ No MD Director HYATTSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4044 HANSON OAKS DRIVE 20784 Funeral USA Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify by Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GROCERY CLERK PRIVATE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN WILLIAMS ဥ MARGARET WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CASSANDRA STANCIL/DAUGHTER 28 GREYSTONE CIRCLE WALDORF, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 11/10/07 LANDOVER, MD 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oropar 011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 🗌 Yes 2 🗌 No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 2 No 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ER/Outpatient Certification: To 1 Inpatient 3□ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours after death To the Funeral Director: To the Hospital

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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Department of H Important: If ite any Injury or otl once,

Physician

The law requires that the death certificate be executed

Attending Physician:

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Division or Vital Records, P.O. Box 68760.

/Medical Examiner

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Ex

Fun Dire

		State of Maryla State of Maryla		artment of I rtificate of			giene Reg. No.2	77 39258
- शर		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
/sicia: ledica		Shonda L. Webster				Nov. 1		2101 M
amine		4a. Facility Name (If not institution, give street and number)		4b. City, Town,		eath	4c. County o	
a made		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In ye	rs. last birthday)	Silver If Under 1 Year		Hrs. 8 Date of Birt	Montgo	9. Birthplace (State or Foreign
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amine	by Fu	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	-	1 ☐ Yes 2 ☒ No		30110 / 110an, 010.)	Specify:	
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e e	Re	17. Father's Name (First, Middle, Last) John H. Webster			1	Name <i>(First, Middle,</i> Hunter	Maiden Surname	·)
matic	2	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Stree		r Rural Route Numbe	er, City or Town, S	State, Zip Code)
ar trai		Sophie A. Webster/Mother				ewark, Ne		
L offi		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location - C	City or Town, State
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any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	I			Marshall' NW Wash		1 Home, Inc. DC 20011
		23a. P. 1. Enter the disease, or complications that caused the decock, or heart failure. List only one cause on each line.	eath. Do not en	ter the mode of dy	ing, such as car	diac or respiratory a	rest,	Approximate Interval Between Onset and Death
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esn J	an/le	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fe		⊒Ectopic pregnanc	CV			of delivery
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ector,	å	25. Was case referred to medical examiner? Hospital:		Ot	hor:	Death (Check only o		
	<u> </u>	27. Manner of Death 28a. Date of Injury	☐ ER/Outpatie	III JUDON	4 LI Nursin	ng Home 5 Resident	dence 6 Other	
e Inue	3110	1 X Natural 5 ☐ Pending (Month, Ďaý Year) 2 ☐ Accident investigation) Injury	of 28c. Inju Wo M 1 [ork?]Yes 2 ∐No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
in fa	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Spe	home, farm, st	reet, factory, office		28f. Location (5 City or Tox	Street and Number	r or Rural Route Number,
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	Ĭ	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
1		Bergit Shoellmy	m	D417	752		11-02-20	07
/		30. Name and address of person who completed cause of death (II Bergit Schoellman 1500 Forest	, , , , .	,	lver Spr	ing, MD	20910	
State	е	21 Date filled (Menth Dev Vern) 20 Berickron's Sin		7				
gistra	r	NOV 0 7 2001 Bases B.	Special .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08473 State of Maryland / Department of Health and Mental Hygiene Ramon D. Ware Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2007 1758 hrs Ware Medical Examiner D. Ramon 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) District Heights Prince George's 2086 Addison Road South If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign New York 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days April 29 1989 18 Director 577-23-1892 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State any 1 X Yes 2 No Prince George's Suitland marked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at once. MD timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene.
1. Filten 27 is marked other than "natural", or items 23a or 28a-f shoror other traumatic event, the Medical Examiner must be notified at oner-Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20746 USA 2304 Brooks Drive # 203 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 X No Specify: **Black** Divorced If Yes, Give Yea Yes 2 X No specify: 3 Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Store Clerk Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Deborah Ware Michael Jervey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2304 Brooks Drive # 203 Suitland, Maryland 20746 Deborah Ware/Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) **Burial 2 Cremation 3 Removal from State 11/7/2007 Clinton, Maryland Resurrection Cemetery Donation 5 Other Specify: 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician Death Madica a. Gunshot wound to back of chest Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be exequted Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the a I be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown ۾ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death After Subject shot Oct 31, 2007 Certification 1755 hrs Yes 2 V No 1 Natural Pending Director: within 24 hours after death.

To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 2086 Addison Road South, District Heights, MD determined (Specify) Apartment Complex 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 1, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day Year) State NOV 0 7 Registrar

David Fowler M.D.

32. Registrar's Signature

Chief Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend 25,27,28a-f, perME,8874, 12/3/07 TT:

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 29, 3:20 PM Robert Elton Wiley, Sr. 2007 Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 1 1 M 2 □ F Director 1940 Louisiana 578-54-5788 May Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits at Silver Spring 1 XIYes 2 □ No Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be re-20904 USA 602 East Randolph Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. s marked other than GSA Federal Police Officer yr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fand Mental H Lois Jones Henry P. Wiley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Item 27 is 1 Silver Spring, MD Sylvia R. Wiley/Wife East Randolph Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Park 11-05-2007 Landover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home, Inc. 20011 4217 9th Street, NW Washington, DC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory failure 2° to right lung collapse **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Ruptured Right Diaphragm Sequentially list conditions. ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examiner Abdominal Aortic Aneurysm and burial-trar be exec Due to (or as a consequence of): Box 68760 CERTIFICATIO Physician/Medical Quadriplegia the as nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ Right Int. Jugular vein thrombosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 1∐ Yes 2 No or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🖾 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¹★Yes -2★ 2 ☐ ER/Outpatient 3 ☐ DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred subject passenger in a car that collided with a motor 28c. Injury at Work? Certification: Division Attending -1 5t Not 5 Pending Injury 2 Accident 3 Suicide investigation 1√ Yes 2 □ No death within 24 hours after death To the Funeral Director: unk 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Rockville Pike near filled in by 4 ☐ Homicide ò Roadway Huntington Dr. Rockville, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Day, Year) D64189

CA (4)

State State NOV 0 7 20

Rama Kapoor

1500 Forest Glen Road,
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silver Spring, MD

20910

07-08769 James White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 38261 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 11, 2007 1733 hrs Medical Examiner James Joseph White 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 9 Whaler Lane Ocean Pines Worcester 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Age (In yrs. last birthday) Months Days Hours Director 098-38-8687 1X M 2 57 09/29/1950 Country) NY Usual Residence of Deceden any 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 No 28a-f show Ocean Pines Worcester hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9 Whaler Lane 21811 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 XMarried Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Yes Widowed Divorced es, Give Yea Yes 2 X No specify: White Specify: þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 1 iment of Health and Mental Hygiene.
 riant: If item 27 is marked other than "i" or other traumatic event, the Medical E s marked other than "r ic event, the Medical F Baltimore, MD 21215-0036 Engineering Tech 1 Enviornmental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Joseph White, Sr. Frances Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen White / wife Whaler Lane, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Buriat 2 X Cremation 3 Removal from State 11/17/2007 Frankford, DE Cape Henlopen Crem. 4 Donation 5 Other Specify 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 26a. Part I. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List on one cause on each line een Onset and /Medical Death a. Occlusive Saddle Pulmonary Thromboembolism Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): b. Bilateral Deep Venous Thromboses Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical the attending physician ed for use as the burial UNPENDED **AMENDED** Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has l performed? ✓ Yes 2 No 2 No 1 🗸 Yes e Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ Other examiner? Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 this 1 V Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 V Natural Yes 2 No Director: d in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the I 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MW lincordi, MID. O.C.M.E. November 12, 2007 homa 30. Name and address of person who completed cause of death (Item 23a)

BA10+1

31. Date filed (Month, Day, Year) 32. Registrar's Signatur 2007 NOV

Assistant Medical Examiner

Donna M. Vincenti, MD

111 Penn Street, Baltimore, MD 21201

State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:05 A^M NOV. 2007 BLANCHE WALTON 10, MAE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 Director 458-32-7687 82 OCT. 8, 1925 TEXAS Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☑ Yes 2 ☐ No Director PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a U.S.A. 9501 BEVERLY AVE. 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 ☐ Widowed 4 ☑ Divorced BLACK Year or Dates: Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 1st BAPTIST CHURCH HOSTESS 10 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be ဂ္ WILLIAM McKINLEY SIMPSON OLIVIA BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an tant: If item 27 is HARDISON/DAUGHTER 9501 BEVERLY AVE., CLINTON, MD. 20735 OLIVIA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRESTVIEW CEMETERY 11-20-2007 | WICHITA FALLS, TX. 21. Signature of Funeral Service License, CHAMBERS CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 207 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed physician and the burial-transit P.O. Box 68760 Physician/Medical for use as attending IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) the 9☐Unknowr 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 TYes 3 Probably 4 □Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 3 DOA 1 Inpatient 2 KER/Outpatient ၉ Division or After this 28a. Date of Injury To the Hospital or Attending Phywithin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1. Naturai 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar LAXMI

31. Date filed (Month, Day, Year)

(Check only one)

ure and title

29b. Signa

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERWA, M.D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Certificate of Death

2. Date of Death

Month

38263

3. Time of Death

6:30

Physician /Medical
Examiner
Funeral Director

1. Decedent's Name (First, Middle, Last)

Ruth Agnes Wolfe

November 6, 2007 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death The Annapolitan Assisted Living Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Days Hours 1 □ M 280% 88 218-03-4370 Jan. 1, 1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2€XNo Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 621 Edwards Road 21409 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Security State of Maryland 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George W. Cromwell Agnes E. Link 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 689 Black Forest Road Annapolis, Maryland Ronald C. Wolfe/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 11/10/2007 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Uneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duis to for as a consecucing of: Physician/Medical Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 25 or Attending Physician: after death. 26. Place of Death (Check only one) Assisted Living 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence & Other (Specify) Facility 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death

Natural

Control

Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the date of the date and place and due to the cause(s) and due 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dhawan, ND D0062534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA DHAWAN, MD 84 Old Mill Brottom Rd N, Annapolis, MD-2140/ 32. Registrar's Signature 31. Date filed (Month, Day, Year) Drew & Speeds Registrar NOV 0 8 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10c,10e,& 10f, per Inf. (874, 12/11/07 TT
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Otato of	mar y lar	Ce			Death	u 1110	inai i iy	Reg. N	200	7	38264
	*	4	Decedent's Name	(First, Middle, La	ast)						2	Date of De	eath			3. Time of Death
24	Physici /Medic			Mee Ying	Kwong Yu						1	Vovembe			Year 2007	11:55 am
	Examir		4a. Facility Name (If	not institution, gi	e street and numb	er)		4b. Cit		Location of De	eath		4	c. County o	of Death	
	A St.	<u>.</u>		uburban Ho		A //	14 h :-46 -1	If I Inc	er 1 Year	ethesda I If Under 24 F	im la	Date of Di	Al-	Mo	ontgo	
Ca.	Funeral Director		5. Social Security Nu 219-72-05 Usual Residence of	09	Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs.	last birthday) Yrs.	Month			lin.	Date of Bir (Month, Da ovember	ay, Yea		9. Birthp	lace (State or Foreign itry) China
	land It		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation							1	0d. Inside City Limits
	Mary fied a	io	Maryland	Montgo	merv	Rock	ville		Pete	mac						1 ☐ Yes 2 🖾 No
	h the	Director	10e. Street and Num		oachway Dri			10f. 2	ip Code	20852			10g. C	itizen of W	hat Coun	try?
	23a cust b		7916 D	eclaration	_					-20854-					U.S.	
	tems ler mi	Funeral	11. Marital Status		12. Was Decede Armed Force	es?	.S. 13.	Was Dec If Yes, s	edent of Hoecify Cuba	lispanic Origin? an, Mexican, Pu	? (Specifuerto Ric	y Yes or No can, etc.)	D*		- Americ , White,	an Indian, etc.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Marrie	4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date					Specify:				Specify:		Asian
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ary	shou and N s mai	-	19a. Informant's Na	me/Relationship	(Type. Print)		19b. Maili	ng Addre	ss (Street	and Number or	r Plural F	Route Numb	er, City	or Town, S	State, Zip	Code)
Σ	t and 2 sl Health an tem 27 is r		Anna Yu	Kwong - Da	ughter					n Lane,	Potor	nac, Ma	ryla	nd 208.	54	
ore	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disp 1 ⊠ Burial 2 [☐Removal from St		Place of Dispo cemetery, cre	matory o	r other place	ce)	Date	е	20c.	Location - (City or To	wn, State
Baltimore,	t. Partmen		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Selvice (Icensee) Washington National Cemetery 11/17/200 22. Name and Address of Facility Hines-Rinaldi Funeral Home											itland	, Mar	yland
Bal	permit. Page Department of Important: If any Injury or once,		21. Signature of Full	neral Service Lice	en see									Spring	g, Ma	ryland 20904
1			23 . Part1. Enter the shock, or lear	ne disease, or cor t failure. List only	nplications that cau	sed the deat h line.	h. Do not en	ter the m	ode of dyir	ng, such as care	diac or r	espiratory a	arrest,			Approximate Interval Between
	Physician	80 0	Immediate Cause (I disease or condition	Final 1	_a. Int	racranea	al Hemor	rhage								Onset and Death
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P.O.	at the de by the a tached	Physician/	1 □ Yes 2 ☑ 9 □ Unknown	No f	9□Unknow	nt at time of o	ieatri 5L	Other	specny) <u> </u>							
	res that t signed by be detact		Part II. Other signif	cant conditions	contributing to dea	th but not res	ulting in the u	nderlying	cause giv	en in Part I.		23e. Did	tobacco	use contri	bute to th	ne cause of death?
or Vital Records,	quires n sigr ald be	d by										10	Yes	2 👿 No	3 ☐ Prob	ably 4 □Unknown
000	aw requires been size should to	Completed										24a. Was		24b. W	/ere auto	psy findings available
Ä	The lay	mo	autopsy performed? 1									d	eath?	mpletion of cause of 2 □ No		
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n C	ding F	ion:	27. Manner of Death 1 Natural	5 Pending		Injury Day Year)	28b. Time o Injury	f M	28c. Injur Wor	yat k? Yes 2 □ No	28	d. Describe	how inj	ury occurre	ed	
Division	Attending r death. ector: After by the funer	icat	2 ☐ Accident 3 ☐ Suicide	investigation	e 290 Place of	iniury - At h	ome, farm, st			res 2 INO	281	. Location	Street :	and Numbe	er or Rura	il Route Number,
D.	tal or frs after al Dire	Certification:	4 ☐ Homicide	determined		, etc. (Specil						City or To	wn, Sta	te)		
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Box 68760, P.O. Division or Vital Records,

Physician /Medical Examiner The law requires that the death certificate be executed sician and burial-tran attending physician for use as the buria the detached sate has been signed by page 2 should be detach certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, completely filled in by the

/Medical

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "in any injury or other traumatic event, the Medione.

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of dertifier

30. Name and address of person

a

hp completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

00

ORIGINAL

l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

29/07

State of Maryland / Department of Health and Mental Hygiene 007 For State Registrar 38266 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 15,2007 Veroncia Adeleke 8:57 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 12637 Council Oak Drive Waldorf Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1963 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 578-82-8362 November Director Washington DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exampler must be notified at 1 X Yes 2 No Maryland Prince George's Waldorf Direct 10f. Zip Code 20601 10g. Citizen of What Country? 10e. Street and Number 12637 Council Oak Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 1 ☐ Yes 2 XNo Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Walter Reed Army Medical Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician Center Twe1th None 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event 20x8. 17. Father's Name (First, Middle, Last) Elizabeth Jackson David E. Dickens 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12637 Council Oak Drive Waldorf, MD 20601 Shawn English/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 23. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2007 Riverdale, Maryland 5 Other (Specify) Riverdale Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope Rd SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diastolic Hypertensive Heart Disease **Physician** HOURS. /Medical Due to (or as a consequence of): Hypertension Years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Obstructive Sleep Aprea, Obesity 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension, Asthma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Left ventricle Lypertrophy. 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of D. aln 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) R. Sindhwan 29c. License number 29b. Signature and title of certifier D0061616 October 17, 2007 R. SINDHWAN 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) waldorf, Pembrooke square, 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State Registrar NOV 3 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 200 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner NIA 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MARVLAN 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗓 F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1. Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a TIHORE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 2 Cremation ± 5 3 Removal from State Important: If any Injury o on 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses Approximate Interval Between Onset and Death of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest pock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and law requires that the death certificate be exe Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending asn 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 ☐ Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of dertifier 29c. License number m

Registrar

State

6701

32. Registrar's Signature

Charles SX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kile

Day,

0

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 38268

		1- For State Registrar				Cer	tificat	e of i	Death					Reg. N	lo		
Physicia dical Exami	an/	1. Decedent's Name		R •		BENNET	יקי	.TP					2. Date of De Month Novemb	eath		ar	3. Time of Death 0055 hrs
13 %		4a. Facility Name (i	if not institution	on, give stre			<u> </u>		Clinton		ocation of				4c. County		
		5. Social Security N		6. Sex	17	. Age (In yrs. ta	ast hirthda	av)	If Under		If Under	24Hrs.	8. Date of E	Birth (N	M/DD/YYY)	7 9. Birt	thplace (State or Foreign
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Baltimore, permit. Pages 1 an Department of Hea Important: If ite		4 Donation 5	Other S												LOR,	II	FUNERAL HM
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Division of Vital Records, P.O. Box 68760, 11 sopilal or Attending Physician: The law requires that the death certificate be remeral Director: After this certificate has been signed by the attending physicial filled in by the funeral director, page 2 should be detached for use as the burit	Certification:	3 Suicide 4 Homicide		uld not be ermined	(Specify)			,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				or Town	n, State	e)		
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řīšří S	Me	29b. Signature and	title of certif		1	//			29c.	License	number		-	2	9d. Date sig	ned (M	onth, Day, Year)
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2		Jack Titus				al Examine		1 Pen	n Street	t, Balti	more,	MD 21:	201				
S	tate	31. Date filed (Mor	nth, Day, Year		27.48	gistrar's Signat	ure	CAM	A Part of the Part								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Robert Baxter 2007 November 01:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 932 Pier Point Drive Pasadena Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 04 Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Months 1 ☑ M 2 ☐ F 92 214-01-4684 Aug. Director MD Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 932 Pier Point Drive 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Properties atth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Α. Baxter Katherin Hickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (grandson) Jeff Riedel 2808 Maize Court, Chester, MD 21619 Date 30 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) |Glen Burnie, Maryland 21. Signature of Fineral Vervice ic nsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, cause on each line. immediate Cause (Final Alzheimers Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ Chronic Anemia 1 ☐ Yes 2 ☐XNo 3 Probably 4 Unknown Completed Hypertensive Arteriosclerotic Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3 DOA Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37229 November 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ana Maria Martinez, 2932A Mountain Road , Pasadena, MD 21122-2014

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) NQV 3 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Mabe Vovember 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stamford Baltimore Koad 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗗 F Months Days Hours Min. SOUTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No 3Ã Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ▶ Burial 2 ☐ Cremation 3 ☐ Removal from State 03-07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2140 M. Fulton Avenue MO. 21. Signature of Funeral Service Licenses H. Brown Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Theimer disease or condition resulting in death) rears Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages Department of Important: If it any Injury or o

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be 2

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

3altimore, Maryland 21215-0036

Physician/Medical Examiner use as the burial-tran attending physician for page 2 should be detached Completed by After this certificate has been To the Hospital or Attending ray within 24 hours after death.

To the Funeral Director: After this certificate

To the Funeral Director, After this certificate

The state of the state of

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2X No 1 ☐ Yes

28d. Describe how injury occurred

3 Probably 4 Unknown

24a. Was an 1∐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes No

25. Was case referred to medical examiner? 1 🗀 Yes 27. Manner of Death 1 Natural 2 ☐ Accident

1 🔲 Inpatient 28a. Date of Injury 5 Pending investigation (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MO

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

5 Residence 6 □Other (Specify)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

HOSPITAL 10 N. GREEN

29b. Signature and title of certifier

0

6 ☐ Could not be

determined

29c. License number 00022432

S 31. Date filed (Month, Day, Year)

Fishman 32. Registrar's Signature

State Registrar

Medical Certification: To Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2-00 7 0233 /Medical Robert Waverly Campbell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Sa Losedale Hospita f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Annths Days Hours Min. January 16, 1908 Greenville, Va. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 10 M 2 F 99 218-03-2991 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at Baltimore 1 □Yes 2 No Director Maryland Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 4102 Taylor Ave. 21236 Completed by Funeral United States Of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes a ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any fijury or other traumatic event, the Medical Examiner any fijury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 3 Widowed 4 ☐ Divorced Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Glenn L. martin Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Ocke V martin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh O. Campbell P Cora V. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly Sherwin 1729 Snowmass Plano, Texas, 75025 Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Evans funeral chape \-Belac NOV. 30.2007 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee EVANS TUNERAL CHAPEL & CREMATIONSERVICES 8800 harford Parkville, Maryland 21234 CULLICU auther 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 26 disease or condition resulting in death) /Medical Due to (or as consequence of): RS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an After this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours anen accome
To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number selle 11/29/2007 D36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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32 Degistrar's Signature

07-09065 Lor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 38272

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		I -	Mr. & Mrs. Cl	nia T. &	Claudia A.	Chen	5328	McKinley	y Stre	et, Be	etnesaa	a. Mai	rvian	d 20814 Town, State
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8	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death	r ^D 28, 2007	3. Time of Death 6:55 A M
	/Medic	al⊹	Ruth K. Calfee 4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Dea	ith
-	/t		Suburban Hospital	//	Bethesda If Under 1 Year		8. Date of Birth	Montgome	
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2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 25 Nidowed Year or Dates:	10	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
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Mary	ind 2 shou alth and M 27 Is mai er traumat		19a. Informant's Name/Relationship (Type. Print) Richard W. Calfee/Son	19b. Maili 3884	ing Address <i>(Street</i> Carriage	and Number or Rura Hill Driv	Route Number, 7e, Fred	City or Town, State, erick, MD	Zip Code) 21704
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Daltimor	permit. Departm Importa any inju	. 1/2	21. Signature of Funeral Service Licensee	M01346 R	2. Name and Address ockville, ockville,	ess of FacilityRobe		umphrey Funtgomery	ineral Home/ Avenue
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as, r.	uires that t signed by Id be detac	ρ	Part II. Other significant conditions contributing to death be	ut not resulting in the u	underlying cause giv	ven in Part I.			to the cause of death? Probably 4 XUnknown
Records	ding Physician: The law req h. After this certificate has beer funeral director, page 2 shou	Completed					24a. Was ar autops perform	ned? death?	autopsy findings available o completion of cause of
NI G	Physician: this certifica ral director, p	Be C	25. Was case referred to medical examiner? Hospital:		Ott	26. Place of Death	(Check only on	9)	
0	Physical this careful direction	7: To	27. Manner of Death 28a. Date of Inju	ry 28b. Time o	III OLI BOX			nce 6 □Other (Sp w injury occurred	ecify)
VISION	Attending r death. ector: After by the funer	ation	1 X Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1]Yes 2□No			
<u> </u>	al or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injuicity building, etc.	ury - At home, farm, st c. <i>(Sp</i> ec <i>ify)</i>	treet, factory, office	1	28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	edical C	29a. Certifier (Check only one) 1	f examination and/or in	ith occurred at the ti nvestigation, in my	ime, date and place, opinion, death occurr	and due to the cared at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	2	29c. Licens D378			od. Date signed (Mon November 2	
			30. Name and address of person who completed cause of d	eath (Item 23a) (Type	. Print)				
	V		Amit Rajvanshi, M.D., 121 C	ongression	al Lane,	#409 Rock	ville,	MD 20852	
	Sta Registr		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) 32. Registr	ar's Signature	Car.				

11/28/07 0655AM

KUTH CALFEE

			Please Type or Print in Black Indelible Ink. Ensure A	•	_	gible.
			State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	Mental Hy	20	07 39271
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D		3. Time of Death
	Physici /Medio		Margaret Elizabeth Dodd	Month	63	2007 8:36 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	_	ity of Death
	Funeral	1	Frantin Square 1405 Pital Rosedale 5. Social Security Number 16. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi	rth DC	1timose 9. Birthplace (State or Foreign
	Director		212 12 0206 1 M 2 F 88 Yrs. Months Days Hours Min.	8. Date of Bi	2 1919	Baltimore, Maryland
	death with the Maryland oms 23a or 28a-f show r must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore County			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28	I Dire	10e. Street and Number 10f. Zip Code 21236		10g. Citizen o	f What Country?
ç	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural," or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	pecify Yes or No o Rican, etc.)		ace - American Indian, lack, White, etc.
12-003b	hours tural"	ed by	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	_		Business/Industry
C1717	ed within 72 rgiene. er than "ne r, the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A College (1-4or 5+) Homemaker	king		eping+Own Home
yrand	ould be file Mental Hy larked oth	To Be (17. Father's Name (First, Middle, Last) Christian Soth 18. Mother's Nam Elizabeth	Gerst		
, Mar	and 2 sh alth and 1 27 is m er traum	1	19a. Informant's Name/Relationship (Type. Print)19b. Mailing Address (Street and Number or RuBeverly F Michel (Daughter)4311 Fitch Avenue Baltimo	re, Md. 2		n, State, Zip Code)
paltimore	Pages 1 anent of He ant: If Item ury or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park Cem. Nov	ember 26		1 - City or Town, State
סמור	permit, Departi Importi any Inj once,		21. Sign study of Funeral Service July nisee 22. Name and Address of Facility Lassann Funeral Home I 7401 Belair Road Balti		vland 21	236
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions.			Approximate Interval Between Onset and Death
/ '00 / 00	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
.O. DOX	w requires that the death certificate be ex- been signed by the attending physician should be detached for use as the buria	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐			Date of delivery Month Day Year
COLUS, T	equires that en signed b ould be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1 □	5.7	ontribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
ו הפכל	hysician: The law r his certificate has be I director, page 2 sh	Completed		24a. Was auto perf 1□ Yes		b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
>	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes No			
5	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; p	-	1 Yes 2 No Nospital Impatient 2 ER/Outpatient 3 DCA Other 4 Nursing Holl 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury 28c. Now 1 Yes 2 Now 2 Accident Novestigation M	ome 5 ☐ Res 28d. Describe	how injury occi	
	tal or Atter s after dea al Director ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Nur wn, State)	nber or Rural Route Number,
	e Hospii 124 hour e Funer letely fill	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the rred at the time	cause(s) and i	manner as stated. e, and due to the cause(s)
	To th Withir To th comp	Me	29b. Signature and fille of certifier 29c. License number D00650	74	11/23	ned (Month, Day, Year)
Ĩ	12		30. Name and address of person who compresed cause of death (Item 23a) (Type, Print) Dr. Binh Ng U yen 9000 Fran/r/in Square D 31. Date filed (Month, Day, Year) NOV 3 0 2007		0 11	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	prive	Baltis	more, MD a173
	Registr		NOV 3 0 2007 Jane St Appendix			

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 8:15AM Physician NOV. JOSEPH G. DOBRY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville Apt. K-307 2300 Dulaney Valley Rd. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Min. Days Hours **Funeral X**(**X**) M 2□ F June 27,1917 Maryland 90 216-01-9441 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland 10b. County 10a. State orant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □ No Lutherville~ Baltimore County Director Baltimore Maryland 10g. Citizen of What Country? 10e Street and Number 21093~2750 USA 2300 Dulaney Valley Rd. Apt. K-307 14. Race - American Indian, Black, White, etc. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 if Yes, Give Year or Dates: White 1 □ Yes 🍇 💆 No Specify. Specify. Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
5 Vrs Elementary/Secondary (0-12) 12 yrs. Aerospace Industry Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Item 27 is marked other any Injury or other traumatic event. Be Helen A. Hartmann Charles T. Dobry, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type. Print) 2300 Dulaney Valley Rd. Apt. K-307 Lutherville, Md. Helen G. Dobry (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition N D Burial 2 □ Cremation 3 □ Removal from State \$acred Heart of Jesus 12-3-2007 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home €. 3 7401 Belair Rd. Baltimore, Md. 21236 assahr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final cardomyorathy YEAVS Schemic **Physician** disease or condition resulting in death) ue to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760c physician a Physician/Medical IF FEMALE: 23d. Date of delivery 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetai death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Kidney discuse Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 \text{No.000} 2 No 1 ☐Yes 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ၉ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 98303 Normber 28 2007 Stranens 30. Name and address of person who completed cause of death (item 23a) (Type, Print) ľV TOWSON MD 21204 N. Charics J. CHAMES 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State care. Registrar

07-09121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam G. Davis	1-	For State	State o	f Maryland		tment of ficate of		Mental I	_	N.	200	17 38276
Dhyminian/		gistrar Decedent's Name (First Middle,Last)			noute or .			2. Date of Dea	teg. No.		3. Time of Death
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Funeral	5.	Social Security Nur	mber 6. Sex	7. Ag	ge (In yrs. las	t birthday)	If Under 1 Year	If Under 241		irth(MM/	DD/YYYY) 9. B Fore	sirthplace (State or
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Division of Vital Records, P.O. Box 68761 tall or Attending Physician: The law requires that the death certificate rall birretor: After this certificate has been signed by the attending phylled in by the funeral director, page 2 should be detached for use as the tartification. To Be Completed by Diveriginal Managed and the physician Managed and the physi	ا ب	25. Was case referre					26.Place	0	neck only one)			
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	should be filed within 72 hours after death with the Maryland und Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show maric event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1	Armed F	2N No	- 1	**			cify Yes or No Rican, etc.)	- 14	Race - Ame Black, White Nico	e etc
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		State	Place of Disport cemetery, cren	natory or othe	r place)		ate		tion - City or	·
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	Physician		Immediate Cause (Final disease or condition		in spurt		Lacker	·					Onset and Death
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6	CXAIIIIICI	<u>.</u>	Sequentially list conditions,	b. Due to	(or as a conseq		rasst						
b	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to		onaulu	au	en					
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o	at the de by the stached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr		eau 3L	Other (speci	y)					
C.	s that ned by	by Pr	Part H. Other significant conditions	contributing to	death but not res	ulting in the ur	nderlying caus	e given in Pa	rt I.	23e. Did t	obacco use	contribute to	the cause of death?
ž	w requires been sign should be									1 🗆	Yes 2□	No 3∏Pr	robably 4 Dunknown
Records,	e law ru has be je 2 sho	Completed								24a. Was	psv	prior to	utopsy findings available completion of cause of
		Con								perfo 1□ Yes	ormed? 2. MNo	death? 1 ☐ Yes	2)SIN0
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ō	Physer this): To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	Inpatient 2□ of Injury	28b. Time of		Injury at Work?		ne 5□Resi 28d. Describe			cify)
0	nding 1 afh. r After e funer	atior	1 Natural 5 Pending 2 Accident investigation	,	nth, Day Year)	Injury	м	Work? 1 ☐ Yes 2	□No				
Division or	I or Atternation after death Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plac	e of injury - At he ling, etc. (Specil	ome, farm, str	eet, factory, o	fice	2	8f. Location (Number or R	ural Route Number,
	oltalo urs aft ora Di												
	To the Hospital or Attending Physician: within 24 hours after deal. To the Funera Director After this certifica completely filler in by the funeral director, i	Medical	29a. Certifier 1. Certifying Pt (Check only one) 2 Medical Example (Check only one)	niner: On the									
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. L	cense numbe	er		29d. Date	signed (Mont	th, Day, Year)
)			Ofit a south	mo				D 605	9 7 3 6		ns	rente	26, 2007
	Λ.		30. Name and address of Jerson who	completed cau	se of death (Iter	n 23a) (Type,							
	ر ا		31. Date filed (Month, Day, Year)	FITLE	Registrar's Signa	mer a	NORT	4 NEST	(+01P17	AL C	5401 0	oro co	INT ROAD
	Sta Registr		NOV 3 0 200	17	Registrar's Signa	4508	March 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie \widehat{n} e0 0 1Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 38 onal 200 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Madison Bultimore 1500 If Under 24 Hrs. 8. Date of Birth

Worth, Day, If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) Days 1 M 2 F 59 214-50-075 yar Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 ¥65 2 □ No to more 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1500 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Earces? 11 Marital Status 1 Pres 2 No If Yes, Give Year or Dates: 2 Married 1 Never Married 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Biddle 2736 20a. Method of Disposition tvan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Garrison Forst Vet Cem 2007 22. Name and Address on Facility /a s Carl ton C. Pouglas 170/ McCulluh ST. 21. Signature of Funeral Service Licensee lass -uneval 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) morario Due to (or as a consequence Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23d, Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 TYes 2 346

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

Funeral

Director

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or Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Madical Examin

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

other traumatic event, the Madical Examinar must be nutified at

Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical

Completed by Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one,

1 TYes 2 No

25. Was case referred to inclical examiner? 1 ☐ Yes 2 € No 27. Mann Ceath 1 Natural

Hospital: 1 Inpatient 2 ER/Outpatient 3 V OA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other

4 ☐ Nursing Home 5 ☐ Idence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Couri no 31. Date filed (Month, Day, Year) NOV 3 0 2007

DIVISIO 1201 32, Registrar's Signature

Registrar

State

Medical

Const

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Eugene B. East 21:20PM EVENSER 26,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner res Da MOI if Under 24 Hrs. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F 214-38-9946 Maryland Director 08/29/1940 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20-4 any injury or other traumatic event, the Mariant 10c. City, Town or Location 10a. State 10d. Inside City Limits Director N/A Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 429 South Gilmor Street 21223 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify:White ģ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Louis B. East, Sr. Evelyn T. Ensey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis B. East (Brother) 429 South Gilmor Street, Baltimore, MD. 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Woodlawn Cemetery 11/30/2007 | Baltimore, Maryland 21 Sign tu of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Phter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A CUTE MYULARDIAL INFARCTION Physician MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IABETES EARS MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner IT YPERTENSION YEARS The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Y No မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: **™**Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital

State

Box 68760

P.O.

Division or Vital Records,

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifler

(Check only one)

OSEPH

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 3 0 2007

buterand NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TWANMOH, MD

32. Registrar's Signature

🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ST- AGNES HOSPITAL,

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Mark William Fuse		S For State	tate of N	1aryland	/ Depart	tment of ficate of	Health ar	nd Mei	ntal Hyg		on No	200	7 3828
Diam'r i air a	R	egistrar . Decedent's Name (First, Mide	dle,Last)			neate of			2.	Date of Dea	th		3. Time of Death
Physician Medical Examine	ı	Mark Wi	11iam	Fuse						Month Novembe	r 21, 2007	Year	1237 hrs
•	4	 Facility Name (if not institut 1654 Whitehead Roa 		et and number)	\	tb. City, Town, o		n of Death			nty of Death	
Funeral	-	. Social Security Number	6. Sex	7. A	ge (In yrs. las	t birthday)	if Under 1 Ye		der 24Hrs.	8. Date of Bi	rth(MM/DD/Y	YYY) 9. Birt Foreig	hplace (State or
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	_	Isual Residence of Decedent			Tage City T	own or Locat	ion						10d. Inside City Limits
w any		0a. State 10b. Count Balt	, timore		Tuc. City, 1	OWN OF LOCAL		imore	9				1 Yes 2 X No
yland a-f sho	힑	Oe. Street and Number					10f. Zip Code				10g. Citizen o	of What Cour	ntry?
he Mai 1 or 28	Ulrector	3108 Richwoo	od Ave	•			2	1244				ted St	
after death with the Maryland all", or items 23a or 28a-f show any mer must be notified at once.	<u>a</u>	11. Marital Status		Was Deceder Armed Forces		. 13. Wa	as Decedent of I	lispanic C an, Mexic	origin? (Spe an, Puerto R	cify Yes or Nican, etc.)		Race - Ameri White, etc.	ican Indian, Black,
r death or ite	Funeral		12		2 No		Yes 2 X				Spe	wh	nite
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Me Me	P	19a. Informant's Name/Relation Rayford Fu	nship (Type, selie:	Print) - / Fat	her	19b. Mailir	ng Address (Si Lost I	reet and N Knife	Number or Ru	ural Route Nu #302 و	_{ımber,} City o Gaith	r Town, State 1ersvu1	e, Zip Code) rg, MD 20886
MD and 2 sho tealth and tem 27 is	ŀ	20a. Method of Disposition			20b. P	lace of Dispo	sition (Name of			Date	20c. Loca	ation - City o	r Town, State
Baltimore, pernit. Pages I ar Department of Hee Important: If tie	1	1 Burial 2 X Cremat 4 Donation 5 Other		Removal from	State	rematory or o esapeal	ke Crema	atory	. 11,	/29/07	Ве	ltsvil	lle, MD
altin mit. P partme portan jury or		21. Signature of Funeral Servi			100382	22.	ices	20910					
		23a. Part I. E ter the disease,	er complicati				Rapp Fur 933 Gist the mode of dy	Ave	. Si	ver S respiratory a	n Serv pring. prest, shock,	or heart	Approximate Interval
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68760 cerificate b nding physi		IF FEMALE: 23b. Was decedent pregnant		3c. If yes, out		-	Fetal death	3 <u>E</u> c	topic pregna	ncy		Date of delive ionth	Day Year
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Medical (29a. Certifier 1 Certifyir one) 2 Medical	Examiner: O	n the basis of	examination a	dge, death oc and/or investi	curred at the tin gation, in my or	ne, date a sinion, dea	nd place, and oth occurred	d due to the d at the time, d	ause(s) and late and plac	manner as s e, and due to	tated. the cause(s)
To the within To the complete	Med	29b. Signature and title of ce	ar	nd manner sta	ted.		29c. L	icense nu	mber		29d. D	ate signed (Month, Day, Year)
		Mllina D	rane	U.M.	14)			C.M.E			Nove	ember 22,	2007
641		30. Name and address of pe		npleted cause istant Med			1 Penn Stre	et. Balti	more. MD	21201			
	t a tr	Melissa Brassell, N 31. Date filed (Month, Day, Y			istrar's Signa	turo 6	la la	,					
Regis	tate tra	MOVO	0 2007	100	the Sign	Astal	all I						

ORIGINAL

		,	For State Registrar	State of	Marylan		artment of I rtificate of	Health and I	Mental Hy	giene Reg. No. 2	007	38	282
	Physicia /Medic Examin		1. Decedent's Name (First, Middle, Last) Estelle Marie Ferguson						2. Date of Death Month 11 / 25 / 2007 3. Time of Death Year 2:00 A				
			4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
	Funeral		Sarah's Plac 5. Social Security Number		7. Age (In yrs. I	last birthday)	If Under 1 Year	nton If Under 24 Hrs.		th	9. Birth	eorge:	
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yland	at		Usual Residence of Decedent 10a. State 10b. County	4 44		y, Town or Lo						10d. Inside Ci	
the Ma	28a-f s	Funeral Director	DC 10e, Street and Number		Was	shing	ton			10g. Citizen	of Mihat Cau	M Yes	2 No
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er deat		uner	11. Marital Status	12. Was Deced	ces?	S. 13.		Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No to Rican, etc.)		Race - Ameri Black, White,		
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death ch line.	h. Do not ent	er the mode of dy	ing, such as cardia	or respiratory a	rrest,		Approximat Interval Bet Onset and	e ween Death
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Or VILLAI Physician:		Be	25. Was case referred to medical examiner?	Hospital:	anationt 2	EP/Outpaties	ot all post of		ath (Check only		As	siste	đ
P Pr		n: To	1 Yes 2 No Indigended 1 Inpatient 2 ER/Outpatient 3 DOA Outret 4 Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?					4 🗆 I turising i	Home 5□ Residence 6▼IOther (\$\overline{\text{Aperiny}}\overline{\text{sted}}\\ \overline{\text{28d.}}\)				
131011		icatic	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury at home farm street factory office					28f. Location (Street and Number or Rural Route Number.					
tal or A		Certification:	4 Homicide determined building, etc. (Specify)										
le Hospi		Medical									s)		
To th		Me	29b. Signature and title of certifier					29c. License number 2 D37243			29d. Date signed (Month, Day, Year)		
30. Name and address of person who completed cause of death (Item 23a)						n 23a) (Tvne			11129101				
	0		Ramesh G.Pate	1,M.D. 7	525 G	reenw	•	.Dr.Sui	te 207	Greer	nbelt	, MD	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 3 0 2	32. Re	egistrar's Signa	ature	20						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM#10b, per H1, 08/3, 11/30/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2Day Physician ROBERT GRAHAM 10:10 AM NOV 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice Center BAUMMORE Gilchvist TOWSON 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number sex 1☑M 2□F **Funeral** Days Hours Months 219-38-9349 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE Md. **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5715 PARK HEIGHTS AVE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 1 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) U. S. GOV. College (1-4or 5+) MILITARY 1201 injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GRAHAM HARRIS DORDITHY and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5715 PARR HEIGHTS Re 92 Baltonice, Ned permit. Pages 1 and 2 to Department of Health ar Important: if Item 27 is any injury or other trau Graham Dorothy mth Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of/Disposition SMINISBURG CIOM. NOV. 26, 2007 SMINISBURG Md.
22. Name and Address of Facility GARY L. ROLLINS FUNDIAL HARE 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee ollis 110 WEST SOUTH ST FREDERICK MO 21701 23a. Part1. Ent - th- disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cute uleks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ☑ No Division or Vital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Spice 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 22, 2007 5205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Chales St. Balto, Md Zc Zd & Rilay 6 BMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 7 2001 November /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner North yrs. last birthday) Itamore NA If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Gountry) 5. Social Security Number 6. Sex 7. Age (Ir **Funeral** 1 M 2 € F 220-18-855 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1 X Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes 2 No Maryland 21215-0036 Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event the Item. Elementary/Secondary (0-12) College (1-4or 5+) DUR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RR ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -NNSYLYANIA Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 □Removal from State TRO CREMATORY IX
22. Name and Address of acility 4 ☐ Donation 5 ☐ Other (Specify) THORE 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4.Pas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner as the burial-transi and The law requires that the death certificate be execu Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of pege 2 has autopsy performed? death? certificate 1∐ Yes 2 No 20 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Tyes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Matural 1 Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 14 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Monin, Day, Year) 29b. Signature and title of certifier

State Registrar 30, Name and address of person who

0 2007

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Laura A. Hurley 9:55A 26, 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Vear | If Under 24 Hrs. Suburban Hospital Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 59 New York Director May 8, 1948 213-54-8138 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or Items 23a or 28a-f show Medic I Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 5911 Johnson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Meone. than Elementary/Secondary (0-12) College (1-4or 5+) Data Management Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Albert George D. McNab 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20853 4416 Ives Street, Rockville, Maryland Nathan M. Hurley/Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State November 28, 2007 Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) rium, Inc. 28, 200/ Betnesda, Flatytand 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 Bethesda, Maryland 21. Signature of Funeral Service Licens M00803 | Rockville, Maryland d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Lymphocytic Leukemia 15 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Eitler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trans Due to (or as a consequence of): Physician/Medical the law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Record 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 📉 No 1□ Yes Vitál 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 24 hours after deatl e Funeral Director; 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) b 5454 Wisconsin Avenue, Chevy Chase, Maryland Nelson_Kalil, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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ORIGINAL

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1- State Registrar Amend Item 5 per fh, g874, 12/05/107dhb

Registrar Regis Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last **Physician** 000 t /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number), 4b. City, Town, or Location of Death Examiner Baltimore City Medic 8. Date of Birth (Month Day Year) 09/05/1934 cial Security Number 9. Birthplace (State or Foreign **Funeral** Country) Months Davs Hours Min. 1⊠M 2□F Director Usual Residence of Deceden 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or items 23a or 28a-f shov Examiner must be notifled at MD Prince Georges College Park 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. 7602 Sweetbriar Dr. 20740-United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: White 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exameny Injury or other traumatic event, the Medical Exameny. Year or Dates: 1957 - 59 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Higher Education College (1-4or 5+) Elementary/Secondary (0-12) Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles S. Johnson Ruth Enger P 19a. Informant's Name/Relationship (Type. Print)
Margaret K. Johnson/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7602 Sweetbriar Dr. College Park, MD 20740-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 27 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc.2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen 1400382 22 Rampant Address of Facility Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910les Tohma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, pe Physiclan/Medical signed by the attending property of the detached for use as IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 X No 3 Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes 2000 No 2□No 1 ☐ Yes Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes P 2 ER/Outpatient 3 DOA funeral 27. Mapner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 ☐ Pending investigation Year 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: / 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2007

31. Date filed (Month, Day, Year)

oldobski

32 Registrar's Signature

			1 - State of Marylai Registrar		artment of F rtificate of			eg. No ?	07	38287	
ş	Physici		Decedent's Name (First, Middle, Last) MARY L. JONES				2. Date of Dea Month NOV .		O 7	3. Time of Death 8:13P M	
/Medica Examine			4a. Facility Name (If not institution, give street and number) FUTURECARE-CHARLES VILLAGE	 2F	4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death		
	Funeral Director		5. Social Security Number 217-68-4313 6. Sex 1 M 2 F 7. Age (In yrs		If Under 1 Year Months Days		8. Date of Birth (Month, Day 5/29/	, Year)	9. Birthpla Counti	ace (State or Foreign ry) RYLAND	
Ē	D	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City							d. Inside City Limits 1 X Yes 2 □ No	
	th with t	Funeral Director	2327 N. CHARLES STREET		10f. Zip Code 21218				USA		
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Xilliand 4 Divorced 12. Was Decedent Ever in the Armed Forces? 1 Yes 2 Xilliand No. 11 Yes 2 Xilliand No. 11 Yes 2 Xilliand No. 11 Yes 2 Xilliand No. 11 Yes 3 Xilliand No. 12 Year or Dates:		S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		
	ithin 72 ho ne. nan "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
	e filed wigher al Hygier other the	Be Cor	5TH 17. Father's Name (First, Middle, Last)	НС	USEKEEP	18. Mother's Name		DOMESTIC , Maiden Surname)			
	d 2 should b th and Ments 7 is marked traumatic e	TOE	UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
	ges 1 and 2 at of Health ar If item 27 is or other trau		ARDIE SHAW / LEGAL GUARDIAN	COMM	ISSION	ON AGINO	$\frac{3}{3} / \frac{10}{8}$	NIMOR TIMOR	EVER'	5 27201	
Baltimore,	Pages ment of I ant: If its ury or o		Bunal 2 Clemation 3 Removal norm state	IT. CA	osition (Name of matory or other plan RMEL CE	м. 11/2		BALTIM	,	, .	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	1/10/10	2. Name and Addre	ess of Facility HOERTY HEI				E 21207	
	<u> </u>		23a. PATE Enter the disease, or complications that caused the deast of the cause of the deast of the cause of	ath, o not ent	ter the mode of dyir	ng, such as cardiac				Approximate Interval Between Onset and Death	
	/Medical Examiner		Immediat cause (Final disease it condition resulting in death) a								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	quence of):	uence of):						
'n	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c Due to (or as a conse	quence of):							
68760,	ifficate be g physicia as the bu	edical	d								
O. Box 6	The law requires that the death certi ate has been signed by the attending bage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregrant 1 □ Live birth 2 □ Ferenant at time of 9 □ Unknown	tal death 3 □	⊒Ectopic pregnanc ∃ Other <i>(sp</i> ec <i>ify)</i> _	у			te of deliver	Y Day Year	
1	uires that signed by d be deta										
Vital Records,	aw requir is been si 2 should	Completed by	24a. Was an autopsy						24b. Were autopsy findings available		
Ĭ E			25. Was case referred to medical			OC Diese of Death	perfor 1□ Yes	med2 2 No	death? 1 ☐ Yes		
	Physiclan: this certific al director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	 ·		4 Mursing Ho	me 5 Resid	ence 6 □Oth)	
DIVISION OF	ending Feath. or: After tuners.	Certification:	27. Manper of Death 1. Manural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred								
2	ial or Attend s after death. al Director: A	Sertific	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
ì	To th withir To th	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signe	a 1-	7	
	7		30. Name and address of person who completed cause of death (Ite DALSHAN S. SALUA 16	m 23a) (Type,	Print) MOUNT	Royal Av	e, Ba	lto 2	121	7	
	Sta Registr	ite	31. Date filed (Mortin, Day, rear) 32. negistral s Sign	lature	ý <u></u>					;	
DH	IMH 17 Rev 1/2	-	NOV 3 0 2007	100	GINAL						
				ON	CHACL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** yra November 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Hospita 0+ Batt, more If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 M Months 212-42-3443 Director larc /an Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Examiner must be notified at 1 Yes 2 Ne Directo Ba Windsor 10e. Street and Numb 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21244 U.S.1 or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Ho If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black 3 Widowed 4 Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be ပ almer 19a. Informant's Name/Relationship (Type. Print) hushq 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 Ha. 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Forest 1/1+ 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non-Small Cell Lung disease or condition resulting in death) Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes Pulmonary 2 No 3 ☐ Probably 4 ☐ Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director: After

29a. Certifier (Check only one) 29b. Signature and title of certifier

Vu

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital

of

29c. License number

000

Baltimore,

29d. Date signed (Month, Day, Year) 2007

Balt, more

2401 W. Belvedere

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 3 0

- WO/1 a

82. Registrar's Signature

case	Type of Finit in Di	ack indelible link.	Liisule Ali	Cobies Wie F
	State of Maryland	Department of He	ealth and Me	ntal Hygiene

Patricia Ann Kerriga	n Stat 1- For State Registrar	e of Maryland	Department of Certificate of		Mental Hy		200	7 3828
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, L Ann Patricia		· · · · · · · · · · · · · · · · · · ·			2. Date of Death Month November	1	3. Time of Death 1852 hrs
(4a. Facility Name (if not institution,			4b. City, Town, or L	ocation of Death	November	25, 2007 4c. County of Deatl	
	2518 Burridge Road			Parkville			Baltimore Cou	
Funeral Director	216 28 3062	Sex 7. Age M 2X F	e (In yrs. last birthday) 75 Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birtl	h(MM/DD/YYYY) 9. Bir Forei	thplace (State or Pennsylvania untry)
any	Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town or Locat	on				10d. Inside City Limits
		timore		kville				1 Yes 2 X No
the Maryland or 28a-f sh iffed at once	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
ith the 1 23a or notifie al Dii	2518 Burridge			2123			USA	Bi-vi
er death with 1	11. Marital Status 1 X Never Married 2 Marr	12. Was Decedent Armed Forces?		s Decedent of Hisp es, specify Cuban,			White, etc.	ican Indian, Black,
s after d	3 Widowed 4 Divorce	ad If Yes, Give Year or Dates:	1	Yes 2 X No	specify:		Specify: Whi	
"natur Exam	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade con College (1-4 or	during m	it's Usual Occupation ost of working life. I			16b. Kind of Business. Nursing	Industry
5-0036 led within 72 hour Hygiene. other than "natu the Mydieal Exar	12	oonege (1-4 or)	Visi	ting Nur	se		Nursing	
15-0 filed w I Hygie ed othe t, the A	17. Father's Name (First, Middle, La William Ker	,		1.	8.Mother's Name Mary Mu	•	Maiden Surname)	
2121 tould be fi d Mental I s marked tic event, To Be	19a. Informant's Name/Relationship	_	19b. Mailin	g Address (Street			nber, City or Town, Stat	e, Zip Code)
MD and 2 sho alth and alth and m 27 is an anmati	Mary Sklar-nie	ece				•	imore, Mary	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the M-drial Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 ABurial 2 Cremation	3 Removal from St	20b. Place of Dispose crematory or ot Sacred Hea			Date 7.30,2007	20c. Location - City o	
altim nit. Pa artmen oortant rry or o	4 Donation 5 Other Spec 21. Signature of Funeral Service Lie	ify:	Ceme	tery Name and Address VANS FUNE		88	 00 Harford	Road
Pe Pe De la la la la la la la la la la la la la	Condiae hy	Mi fared		ID CREMAT!	IONS SER	VICES	Parkville	e,MD 21234
Physician /Medical	23a. Part I. Enter the disease, or co failure. List only one cause or	each line.						Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	therosclerotic Card equence of):	iovascular Dise	ease complic	ating Fractu	red Leg	Death
	Sequentially list conditions, if any, leading to immediate	b	equence of):					-
ted misit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c						
uted Idea Idea Idea Idea Idea Idea Idea Id	events resulting in death) Last	Due to (or as a consid.	equence of):					
ox 68760, eath certificate be executed attending physician and for use as the burial - transit sician/Medical Ex	UNPENDED	$_{ m X}$ AMENDED 1 ${ m p}$	er meo g873	11-30-07	vt vt			
6876C certificate of nding physics as the bhilds.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth		etal death 3	Ectopic pregna	ancy	23d. Date of delive Month	ry Day Year
Box 6: death cert the attending of for use a hysicia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at	time of death	ther (Specify)		,		,
O. B. nat the de side by the etached for y Phy.	Part II. Other significant condition	9 Unknown	h but not resulting in the	underlying cause gi	iven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
cords, P.O. B law requires that the d has been signed by the 22 should be detached mpleted by Phy	Osteoporosis					1 Yes	s 2 No 3 Pro	obably 4 Unknown
Vital Records, hysician: The law requires this certificate has been significate, page 2 should be to Be Completed						24a. Was autop	osy prior to	utopsy findings available completion of cause of
tal Rec crian: The la certificate h ector, page.						1 🗸 Yes	rmed? death? 2 No 1	
Vital Rec ysician: The list certificate director, page	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2 ER/Outpatien		of Death (Check Other: Nursir		Residence 6 ✓ Oth	er: Scene
of Viving Physic and Physic The I are To I	1 V Yes 2 No 27. Manner of Death	28a. Date of Inju	ury 28h Time of		y at Work?	28d. Describe I	how injury occurred fracturing leg	
Division Isla or Attendir rs after death. al Director: A led in by the fu	1 Natural 5 Pendin 2 ✔ Accident Investi	nov 25, 2007	7 1846 hrs		es 2 V No			
Division o Biopital or Attending 24 hours after death Funeral Director: Aftered in by the fem all Certification:	3 Suicide 6 Could determ	not be	njury - At home, farm, stre ngle Family Home	ет, тастогу, опісе ві	uliding, etc.	or Town, S	Street and Number or F State) e Road, Parkville, Mi	tural Route Number, City
0 - = 5	29a. Certifier 1 Certifying Phy	sician: To the best of m	ny knowledge, death occu					
To the Howithin 24 within 24 To the For completed	29b. Signature and title of certifier	and manner stated.		29c. License		at the time, date	29d. Date signed (M	
	(Y and al	MAN		O.C.N	Л. Е.		November 26, 2	•
6	3 Na and address of person w		, ,	Street D-W	NAT OLG	201		VC2
State			ar's Signature	n Street, Baltim	iore, IVID 212	.01		
Registrar	I amaza da da	2007 Jaca		new .				

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OCME

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Maryland

Baltimore,

Physician Ernest H. Kuehne /Medical 4a. Facility Name (If not institution, give street and number) Examiner **Funeral** Director 212-26-7613 Usual Residence of Decedent death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director MD 10e. Street and Number Funeral 11215 Arbutus Avenue 1 Never Married 2 Married Be Completed by 3 Widowed 4 Divorced Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Frank Kuehne 19a. Informant's Name/Relationship (Type. Print) <u>Bertha B. Kuehne</u> 20a. Method of Disposition 1 Magazial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-transit and physician as IF FEMALE: for use 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No , page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Be Completed by certificate has been funeral director, 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To this 27. Manner of Death After Hospital or Attending 1 Natural death. 2 Accident after death completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 200 30., Name and address of person who completed cause of death (Item 23a) (Type, Print) PFEFFER MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MOVE

Drivin 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 28 Physician 3,30 Young Sung Lee /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ **Director** 215-08-1081 91 29,1916 Korea Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f sh 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a must b 671 Willowby Run 21122 South Korea Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item: ledical Examiner n Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 2 Specify: 3 ☑ Widowed 4 ☐ Divorced Asian Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stee1worker Steel Manufactruing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: if item 27 is marked of marked Lee Do Chong ၀ She Gu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Y. Lee / Son 671 Willowby Run, Pasadena, Maryland 21122 tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of F Important: if ite any injury or oth 1 ☑ Aurial 2 ☐ Cremation 3 ☐ Removal from State Dec. Meadowridge Mem. Park 2007 4 □ Donation 5 □ Other (Specify) Elkridge, Maryland ral Service Z2. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Signat MY 16 MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 20515 /Medical Due to (or as a consequence of): Examiner veumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 🗷 Unknown 1 □ Yes 2 □ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate ha 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 212 No 1 🖺 Inpatient ၀ 2 ER/Outpatient 3 DOA this 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Maryland 21215-0036

altimore,

28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

November 28, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20a) (Type, Print) 301 Haspital Drive, Glen Burnie, Maryland 21061

State Registrar 31. Date filed (Month, Day, Year) NOV3 0

32. Registrar's Signature

			State of Maryland / D	•		lental Hyg	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Death	2. Date of Dea	leg. No.2 0 0 7	38292	
	Physicia	an	Walter L. Lawrence			Month Novembe	Day Year	10:08 A ^M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, c	4b. City, Town, or Location of Death 4c. County of I				
	Examin	٠.	Carroll Hospice Dove House	Westn	Westminster Carroll				
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birth</i>	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	(, Year) Co	hplace (State or Foreign untry)	
U	Director		214-48-9299 124 60 Y	rs.		August 30), 1947 Wash	ington, D. C.	
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. Arked other than "natural", or Items 23a or 28a-f show afte other than "natural", or Items 23a or 28a-f show afte event, the Medical Examiner must be notified at		10a. State 10b. County 10c. City, Town	or Location		-		10d. Inside City Limits	
	a-f sh ified	tor	Maryland Frederick Midd	lletown				1 □Yes 2 X No	
	or 28	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Co	ountry?	
	ath w		7300 Countryside Drive		21769		United Sta		
	ltems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	 Was Decedent of If Yes, specify Cub 	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
36	urs aft	by	1 Married 2 Married 1 Mar	1 ☐ Yes 2 💢 No	Specify:		Specify: W	nite	
9	72 hou	Completed		Decedent's Usual Occup (Give kind of work done		vina .	16b. Kind of Business/		
21	ithin 7 ne. nan "r Med	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retire	ed)	,	Archdioces Washington	e of	
7	lled w Hygier her th	ပိ	5+ Ca	tholic Prie	1		Maiden Surname)		
anc	d be fi	Be	Duane G. Lawrence						
Ž	should nd Me mark mark	ရ		Mailing Address (Street		Jean Wic	er, City or Town, State, 2	Zip Code)	
Š	alth a 27 is er trau		Betty Jean Lawrence / Mother 730	0 Countrys	ide Drive	, Middle	etown, Mary	land 21769	
ore	of He fitem		20a Method of Disposition 20b. Place of I	Disposition (Name of v, crematory or other pla		pate per 4,	20c. Location - City or		
Ĕ	ment ant: I			Heaven Cemet	ery 200	7	Silver Spring	, Maryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee M01305	Robert A. Pu	ess of Facility Imphrey Fun	eral Home	/Rockville, I ville, Maryla	nc.	
	4-,-31		23a. Part1. Enter the disease, or complications that caused the death. Do no	•				Approximate Interval Between	
	Physician	1	shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Ken ia				Onset and Death	
1	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of	-				J M.	
E	Examiner		Sequentially list conditions, b.						
9	pei isit	nine	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause (Disease of injury	1):					
$\widetilde{\mathcal{Y}_{b}}$	execul n and al-trar	Examiner	that initiated events resulting in death) Last C	f):					
8760,	cate be executed physician and the burial-transit	dical E	d						
9	ng ph	Medi	IF FEMALE:						
Вох	ath ce ttendi or use	ian/l	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnanc	Э		23d. Date of de Month	livery Day Year	
P.O.	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify) _					
	that the ded by	/ Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to	o the cause of death?	
rds	The law requires that the death certifit ate has been signed by the attending F rage 2 should be detached for use as	d by				1 🗆 🗅	res 2 No 3 P	robably 4 Unknown	
000	aw rei	Completed				24a. Was		utopsy findings available	
Ä	The I	mo				autop perfo 1□ Yes	rmed2 prior to death? 2 ☑ No 1 ☐ Yes	completion of cause of s 2 □ No	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?		26. Place of Dea				
or Vital Records,	Physical this call direct	^L	1	patient 3 DOA			dence 6 dther (Spe	Hospies	
O	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) In	ijury Wo	ork?]Yes 2 □ No	Zod. Describe i	now injury occurred	416.03	
Division	Attending Physician: r death. ector: After this certification the funeral director.	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, far			28f. Location (S	Street and Number or R	ural Route Number,	
á	Hospital or Attending I 24 hours after death. Funeral Director: After itely filled in by the funer	Certification:	4 Homicide determined building, etc. (Specify)			City or Tov	vn, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Check only one) (Check only one) Check only one) (Check only one) And manner stated.	death occurred at the t l/or investigation, in my	time, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier		se number		29d. Date signed (Mon	th, Day, Year)	
			Cind 3en	D.	16737		11/27/07		
	10		30. Name and address of person who completed cause of death (Item 23a) (Michael R. Behre, MD, 300 South Chu		, Middlet	own, Ma	ryland 2176	59	
7.	Sta Registr		31. Date filed (Month, Day, Year) NOV 3 0 2007 Registrar's Signature			-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, **Physician** November 2007 06:00 a M Gloria Μ. Mentis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 500 University Parkway Apt. 4K N/A Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/27/1933 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗙 F 213-78-4011 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1803 Thornbury Road 21209 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Mentis ပ Angela Failla 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 W. University Pkwy. Apt. 4K Baltimore, MD 21210 Betty C. Mentis, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hôly Redeemer 11/30/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. lapandia & Blan 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician loy /Medical Examiner Sequentially first conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine hysician and the burial-transi Due to (or as a consequence of) Physician/Medical 33 IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page certificate 000 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) (5.7 E.2 S 1 Tes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: A the filled in by

altimore, Maryland 21215-0036

Certification: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMANA GOPALAN M.D., ZERULLING

BALTIMORE 2122

State Registrar

6

32 Registrar's Signature 31. Date filed (Month, Day, Year)
NOV 3 0 2007

			1 - For Registrar	State of N	laryland / Dep			lental Hygie	3	38294
	Physic /Medi Exami	cal	Decedent's Name (First, Middle Dorothy P. Mac 4a. Facility Name (If not institution)	samen	r)	4b. City, Town, o	or Location of Death	2. Date of Death Month 11	Day Year 27 2007 4c. County of Death	3. Time of Death 10:40 P, M
	Funeral Director		Franklin Woods 5. Social Security Number 120-10-6817 Usual Residence of Decedent	5	nge (In yrs. last birthday) 93 Yrs.			land 8. Date of Birth (Month, Day, Y 05/31/1	Baltimo: 9 Bint 9 Bint 9 Bint Cou 914 Mar	re place (State or Foreign cyland
	the Maryland 28a-f show	rector	10a. State 10b. County	cimore	10c. City, Town or Lo			100	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 X No
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show ha Medical Evaminer must be notified at	eted by Funeral Director	9200 W. Frank 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced 15. Deceden (Specify only highes	12. Was Deceder Armed Forces 1 □ Yes 2 ₹ 11 Yes, Give Year or Dates	t Ever in U.S. 13. 13. No 16a. Dece	21 Was Decedent of It Yes, specify Cub 1 □ Yes 2X No		ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Amer Black, White	ican Indian, , etc. ite
and 2121	should be filed within nd Mental Hygiene. I marked other than "umatic event, the Me	o Be Completed	Elementary/Secondary (0-12) 12. 17. Father's Name (First, Middle,	College (1-4o	r 5+) life.	DO NOT use retire nemaker	18. Mother's Name	e (First, Middle, Ma		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event. If a Medical Examirer must be notified at once.	To	Harry Crawfor 19a. Informant's Name/Relations Clinton D. Mags 20a. Method of Disposition X Burial 2 Cremation 4 Donation 5 Other (S.) 21. Signature of Funeral Service	hip <i>(Type, Print)</i> samen, Jr. (3 □Removal from Stat oecify)	son) 4740 205. Place of Disport Cemetery, cree Camp Char	Water Pa position (Name of matory or other pla cel UM Ch 2. Name and Addre	rk Drive ce) Cem. 12/0 ess of Facility E.	Belcance 3/2007 Ba F. Lassa	City or Town, State, Z. Marylan C. Location - City or 1 altimore, I	d 21017-1508 Town, State Maryland l Home, P.A.
68760,	ate be executed which and was an analysician and burnal-transit and the burnal-transit and	ical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Undersoon in the cause resulting in death) Last	a	s a consequence of):	ter the mode of dyii	ng, such as cardiac d	or respiratory arresi	t,	Approximate Interval Between Onset and Death
P.O. Box 68	ath certifica ttending pl or use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	у		23d. Date of deliver Month	very Day Year
Records, P.	w requires that the de s been signed by the a should be detached f	Completed by Ph	Part II. Other significant condition Peep Vein Horn Luce and	ns contributing to death	but not resulting in the u A leg Cor a hete me	gestive	ven in Part I.		24b. Were aut	obably 4 Unknown
Vital	Physician: The lav this certificate has ral director, page 2 a	o Be	25. Was case referred to medical examiner?	Hospital:	tient 2 ER/Outpatier	011	200	autopsy performe 1 ☐ Yes 2 ☐	prior to co death? 1 ☐ Yes	ompletion of cause of
Division of	De fe	Certification; T	27. Manner of Death 1	28a. Date of Ing (Month, D		f 28c. Injui	ry at rk?	28d. Describe how	et and Number or Rui	
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Co	29a. Certifier (Check only one) 29b. Signature and title of certifier	g Physician: To the bes Examiner: On the basis and manner s	of examination and/or in	h occurred at the til vestigation, in my c	ppinion, death occurr	ed at the time, date	and place, and due	to the cause(s) Day, Year)
)	5		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print) DAS	766 431 B		1-28.07 -e, MD	
	Sta Regista		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature		10 010	wy / Jur (V)	- / / / /	15)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11 24 2007 9:00p Marshall /Medical Rena 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Joseph Richey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√□ F 79 Director 239-52-7688 08 11 28 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with or Items 23a or 21217 U.S.A. 2477 Druid Hill Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or iter ury or other traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Airport House Keeping 9th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Jenny Douglas ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2767 Windy Hill Road, Marietta, GA 30067 Evelina Marshall-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory Inc 11/30/2007 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conseq Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Types 2 TNo the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co ute to the cause of death? Completed by 2 2 0 1 🔲 Yes 3 Probably 4 Unknown certificate has been s rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performe 2 1 No 25. Was case referred to nedical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes To 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural (Month, Day Year) 1 □ Yes 2 □ No. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Records, Division or Vital

mayshall

Baltimore, Maryland 21215-0036

or Attending Physician: within 24 hours after death.

To the Funeral Director: After this à the Hospital

> J State Registrar

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 0 2007

29a. Certifier

29c. License number

1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

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Ĺ	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>līn yrs. lastı</i> 70	birthday) _ Yrs.		Hours 4	Min.	B. Date of Bird (Month, Da AUG .	27,193	9. Birthpl	lace (State or Foreign try) ARYLAND
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Baltimore,	t. Pag rtment rtant:		4 □ Donation 5 □ Other (Specify) HOL		SARY CEM						
Bal	permit. Pages 1 and 2 & Department of Health as Important: If Item 27 is any injury or other trauonce.		21. Signature of Funeral Service Licensee		Name and Address PO1 EAST	ETLE: ERN	R II AVEI	NC. FINUE, B	UNERAL ALTIMO	HOMI RE,MI	E D. 21231
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Box	leath certific attending p	M/ug	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dec		Ectopic pregnancy				23d. Da	ate of delive	ry
O. B.	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 gronths? 1 Yes 2 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown		Other (specify)				М	lonth	Day Year
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Division or	r Atte er des irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	- 12 2 1 2	28	f. Location (S		ber or Rura	I Route Number,
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	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated.	and/or inv	estigation, in my opir	, date and nion, death	place, ar occurre	d due to the d at the time,	cause(s) and m date and place	anner as st , and due to	ated. the cause(s)
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	X		30. Name and address of person who completed cause of death (Item 23	a) (Type, P	Print)	C. 1	11	01	2011		nad In
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	9	XX J.	CIVIL	ene	J+.	Dun	nove	14(1) 0170
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DHMH 17 Rev 1/2001

Physician	
/Medical	
Examiner	

Director

Funeral Director

show ral", or items 23a or 28a-f shov Examiner must be notifled at with the death Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 'natural", or of Hygiene.

other than "natura /ent, the Medical E permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, <u>tr</u>

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-transi physician s the burial as use Por ed by the a detached f certificate has t rector, page 2 s Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Records, P.O. Box 68760,[¢]

Division or Vital

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WINIFED

Funeral þ Completed Be ပ Examiner Physician/Medical IF FEMALE: ò Completed Be Medical Certification: To 29a, Certifier

 Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2007 Year November 1:00 P M Winifred Lion Morris 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bethesda Montgomery Surburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 27, 1916 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2 V F Alabama 91 421-24-8835 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Potomac Maryland | Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20854 United States 11215 Seven Locks Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Specify 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Libarian Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Letitia Clancey Charles Lion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9204 Falls Bridge Lane, Potomac, Maryland 20854 Winifred M. Ely/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 27, 2007 22. Name and Address of Facility Robert A. F Bethesda-Chevy Chase Inc., Bethesda, Maryland 20814. A. Pumphrey Funeral Home 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate dauge. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Non-Insulin Dependent Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed' 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1☐ Yes 2☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔀 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 24, 2007 D37891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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State Registrar 31. Date filed (Month, Day, Year)

A. Rajvanshi, M.D., 121 Congressional Lane #409, Rockville, Maryland 20852

32. Registrar's Signature

Bert Rud

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:42 AM M 2007 November 27, Jessie Helen Nygard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15115 Interlachen Dr. #810 Silver Spring
If Under 1 Year | If Under 24 Hrs. | 8. Date of Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours Min Months Days 1 □ M 2 🔀 F 97 05/16/1910 Director NC 239-09-1147 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 22a and any injury or other trainment. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20906-15115 Interlachen Dr. #810 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? I □Yes 2 🛣 No f Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Personnel Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Cockran Floyd Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9402 Columbia Blvd. Silver Spring, MD 20910-Robert H. Huber, Jr./Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DEC. 31, 2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 22. Name and Address of Facility 21. Signature of Funeral NU0382 ShallDLolin Rapp Funeral & Cremation Services nem 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cerebroughedan **Physician** two weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-trar Due to (or as a consequence of): physician at the burial Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an cate has t autopsy performed? res 200 No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ို this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

P.O. | Division or Vital Records, or Attending Physician: After

thin 24 hours area control of the Funeral Director: Aff

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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752481 Nille in her 78

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Ovive, suite 304 Plotter MiD 18111 Prince Olney, Marine 2083) 1)avid 31. Date filed (Month, Day, Year)

State Registrar

Medical

0 2007

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit

Division or Vital Records, P.O. Box 68760,

an al	Steph	en O. N	1	5						Novembe	er 28	,2007 ^{Ye}	ar	1:20	Рм
er	4a. Facility Name (II			umber)		4b. City, T			of Death			County of D		ro	
	5. Social Security N	st Hospice	Sex	7 Age (In yes	. last birthday)		OWS	If Under	24 Hrs.	8. Date of Birt				ace (State o	r Foreign
	216-14-		X M 2□F	8.		Months	Days	Hours	Min.	(Month, Da Nov. 2	2 , 19	22 M	ary	land	ii i dieigii
	Usual Residence of	Decedent													
	10a. State	10b. County		10c. C	ity, Town or Lo								10	0d. Inside Ci	
cto	MD	Bali	timore		F	Parkvi	TTe				1 □Yes 2X No				2 X No
Ji e	10e. Street and Nur	mber				10f. Zip	Code			10g. Citizen of What Country?					
ral	8820 Wa	alther B			212				US						
nne	11. Marital Status		Armed F		J.S. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	spanic Or n, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - A Black, V 			
γF	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married	1 LXYes If Yes, G Year or	2 □ No Bive		1 ☐ Yes 2	Z.No	Specify:				Specify:		White	
To Be Completed by Funeral Director	3 🗆 Widowed	15. Decedent's		Dates.	I 16a Dece	dent's Usual	l Occuna	ation			16h Kin	d of Busine	ee/Ind	lustry	
olet		cify only highest g	rade completed		(Give	kind of worl	k done o e retired	during mos	t of work	ing	i i	P Tel			
luo	Elementary/Seco	indary (0-12)	College	(1-4or 5+)	Te	chnica	an			i		ompar		ione	
e C	17. Father's Name	(First, Middle, La	st)					18. Moth	er's Name	e (First, Middle,	Maiden S	Surname)	.=		
0.0	Edwar	d J. Nic	chols					Elsi	ie E.	. Oursle	er				
	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Maili	ng Address	(Street a	and Numb	er or Rur	al Route Numb	er, City or	Town, Sta	te, Zip	Code)	224
	M.Marguer	rite Nicl	nols-spo	ouse	8820	Walth	herB	lvd.	Apt.4	1417–Pai	rkvil	le,Ma	ryl	and ²	234
	20a. Method of Disp	oosition Cremation 3	□ Domoval from	20b.	Place of Disponent Center La	osition (Namematory or ot	e of her plac	£)η : π		Date 2007		ation - City			
		5 ☐ Other (Spec		in State C	Gard	lwn Mei lens	IOLI	aT 1	ec,	,		•		yland	
	21. Signature of Fu			,	2	2. Name and	Addres	s of Facili	ty IADFI	8800		ford			
		al KM				ANS FO						lle,M	lary	land	21234
	23a. Part1. Enter to shock, or hea	he disease, or co ort failure. List on	mplications that ly one cause on	caused the dea	ath. Do not en	iter the mode	of dyin	g, such as	cardiac	or respiratory a	rrest,			Approximat Interval Bet	ween
	Immediate Cause (disease or conditio	(Final n	, C	hvoi	1,0	065	SV	vot	zui	ling	dis	SEASI		Onset and I	
	resulting in death)	4	Due to	o (or as a conse	quence of):										
L	Sequentially list conditions, if any, leading to infiniediate cause. Enter Underlying Cause, (Disease or injury)								_						
ine	cause. Enter Unde	erlying	Due to	tor as a conse	quenes on:										
xan	that initiated events resulting in death) I	6	c Due to	o (or as a conse	quence of):								+		
Completed by Physician/Medical Examiner					,										
edic			0												
N/N	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, o	utcome pf pregi	nancy						2:	3d. Date of	delive	ery	
icia	in the past 12 1 ☐ Yes 2 ☐	months?	4□Pre	birth 2□Fe gnant at time of		□ Ectopic pregnancy □ Other (specify)				Month Day Year					
hys	9 □ Unknown		9□Unk	nown											
y P	Part II. Other signif	ficant conditions	contributing to	death but not re	suiting in the ι	inderlying ca	ause give	en in Part	1.	23e. Did t	obacco us	e contribu	te to th	e cause of o	death?
g pa	Conges	true H	eart.	fail.	une.	CONI	200	my		12	Yes 2□]No 3[Prob	ably 4 □ l	Unknown
plet	Hehri	tdis.	ease	, de	alie	tes				24a. Was		24b. Wer	e auto	psy findings	available
mo	moll	itus		,						auto perfo 1 Yes	ormed?	deat	h? Yes	npletion of c 2□ No	ause of
BeC	25. Was case refer examiner?	red to medical						26. Place	e of Deat	h (Check only o					
	1 Yes 2 €	Νο	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3□ DO	A Othe	er: 4□N	ursing Ho	ome 5 ☐ Resi	dence 6	☐Other (Specify	0/ 03	pean
:uc	27. Manner of Deat	th 5 ☐ Pending	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time of Injury	of 28	Bc. Injury Work	y at c?		28d. Describe	how injury	occurred			
atic	2 Accident	investigati 6 □ Could not	ho			М		Yes 2□	No						
ij	3 ☐ Suicide 4 ☐ Homicide	determine	28e. Plac	ce of injury - At liding, etc. (Spec		reet, factory,	, office			28f. Location (City or To		l Number o	r Rura	l Route Nun	nber,
ပိ	29a, Certifier	1 Certifying	Physiclan: To the	he heet of my kr	nowledge dea	th occurred s	at the tin	no dato a	nd place	and due to the	cauco(c)	and manne	v ac ct	tatod	
Medical Certification: To	(Check only one)	2 Medical Ex	aminer: On the												s)
Me	29b. Signature and	title of certifier	15	2		29c	. License	e number			29d. Date	signed (N	fonth,	Day, Year)	
	19/	Mithu	1 Ril	my r	2	1	12.	520	U		Nou	1em	nev.	28,20	700
	30. Name and add	ress of person wh	o completed car	use of death (Ite	em 23a) (Type	, Print),		46							<u> </u>
	WAR	: Ley. 6	BMC	6701	Ne	Chin	les	St-	Bo	Ct. 1	Nd	202	0 5	c	
te ar	31. Date filed (Mon	th, Day, Year)	2007 32	de strar's Sigi	nature	-									

DHMH 17 Rev 1/2001

State Registrar

oseph Edward O	1	thony State of Mary - For State Registrar		t of Health and Men e of Death		J. No. 200	7 3830
Physiciar Medical Examin	1/	Decedent's Name (First, Middle,Last)	Edward O'Maho	m.;	Date of Death Month November	Day Year	3. Time of Death 1835 hrs
realear Examin		4a. Facility Name (if not institution, give street and		4b. City, Town, or Location of		4c. County of Death	
E	4	4826 Fort Sumner Drive 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Bethesda y) If Under 1 Year If Under	er 24Hrs. 8. Date of Birth	Montgomery (MM/DD/YYYY) 9. Birth	nplace (State or
Funeral Director		063-18-7084 1X M 2 Usual Residence of Decedent		Yrs. Months Days Hours	Min.	Foreign	
* any		10a. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
Maryland 28a-f show any d at once.	흱	Maryland Montgomery		Bethes 10f. Zip Code		g. Citizen of What Coun	1 Yes 2 X No
with the Maryland ins 23a or 28a-f sho be notified at once.		4826 Fort Sumn	er Drive	208		United S	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. Red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed	Forces?	B. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	, Puerto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
rs after ural", c	ᇍ	3 Widowed 4 Divorced If Yes, Give or Dates: 15. Decedent's Education (Specify only highest of the second of the s		1 Yes 2 X No specify: cedent's Usual Occupation (Give		Specify: 16b. Kind of Business/Ir	White
72 hou nati	eted			ing most of working life. DO NOT			•
MD 21215-0036 d 2 should be filed within 72 hours after the and Mental Hygiene. n 27 is marked other than "natural", summatic event, the Medical Examiner.	Completed	17. Father's Name (First, Middle, Last)	5+ F	oreign Service	Officer 's Name (First, Middle, M		t of State
215- oe filed ntal Hyg ked otl	Be C		eph O'Mahony	, c.ivicuio		a Hermann	
Z 5 6 6 2		19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street and Nur		-	
C. E es F	ŀ	Helen Merle O'Mahon 20a. Method of Disposition	20b. Place of D	26 Fort Sumner Disposition (Name of cemetery,	Drive, Beth	1esda, Mary 20c. Location - City or	
[등 등 을 수 교.		1 Burial 2 X Cremation 3 Remove 4 Donation 5 Other Specify: 21. Signature of Funeral Service License	l ('rams	or other place) ontgomery atorium Inc.	November 28, 2007	Bethesda,	Maryland
Balt permit. Departu Import injury	-	Xen Veral	м00335	22. Name and Address of Facilit Bethesda-Chevy Bethesda, Mary	Chase Inc. Land 20814-3	7557 Wisco	onsin Avenu
Physician /Medical		23a. Part I. Effer the disease or complications the failure. List only one cause on each line.	at caused the death. Do not e	nter the mode of dying, such as o	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
kaminer			Shrapnel wounds with as a consequence of):	complications			Death
	<u>آ</u> و		as a consequence of):				
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Sox 6876 leath certificate e attending phy for use as the l	Physician/M	past 12 months?	ve birth 2 egnant at time of death 5	Fetal death 3 Ectop Other (Specify)	ic pregnancy	Month [Day Year
BO) ne death the att	hysi		nknown		leet I 230 Did to	bacco use contribute to	the cause of death?
, P.O. res that th	<u> </u>	Part II. Other significant conditions contributing	ng to death but not resulting li	n the underlying cause given in P		2 ✓ No 3 Prot	
ords, w requires been signed by	Completed				24a. Was a		topsy findings available completion of cause of
Reco The law cate has	dmo				perfor 1 Yes	med? death? 2 ✔ No 1 Ye	es 2 No
Vital Rec ysician: The his certificate I director, page	8	25. Was case referred to medical examiner? Hospital: 4	Inpatient 2 ER/Outp	26.Place of Death patient 3 DOA Other		Residence 6 ✔ Othe	r Scene
1 of Ving Phys	٤	1 Yes 2 No 27. Manner of Death 28a. D		ne of Injury 28c. Injury at Wor	k? 28d. Describe t	now injury occurred uring World War 2	
Sion Attendin death. sctor: A	cation	2 Accident Investigation		1,00 2	NO NO	Street and Number or Ru	
Division spital or Attendi hours after death. neral Director:	Certification:	3 Suicide 6 Could not be	Place of Injury - At nome, family Offy) Unknown during to	n, street, factory, office building, e	or Town, S Unknown, ,		irai Route Number, Oity
	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the bar and poant	sis of examination and/or inv	occurred at the time, date and p estigation, in my opinion, death o	lace, and due to the caus ccurred at the time, date	e(s) and manner as stat and place, and due to th	ed. ne cause(s)
F 3 F 8	Me	29b. Signature and title of certifier	or stated.	29c. License numbe	r	29d. Date signed (Mo	
N		Chul	source of death (Here 200)	O.C.M.E.		November 28, 2	
30×1		30. Name and address of person who completed David Fowler M.D. Chief Medica	al Examiner 111 Pe	nn Street, Baltimore, MD	21201		
Sta Regist		31. Date filed (Month, Day, Year) 32 NOV 3 0 2007	Registrar's Signature	fred 2	<u>-</u>	<u>.,, .</u> ,	
DHMH 17 Rev 1/20	01	7	ORIO	SINAL			

Registrar DHMH 17 Rev 1/2001

State

12.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HENRY L. RICE 25 2007 NOV 10:33A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Months **№** M 2□ F 64 217-40-5624 5/27/1943 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1X Yes 2 □ No MD BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4407 SPRINGDALE AVENUE 21207 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DUTY NURSE 12TH MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOROTHY PARHAM GEORGE H. RICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type. Print) ADRIAN RICE-MAYNARD/ DAUGHTER 3225 BRENDAN AVE, BALLTIMORE, MÕ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) KING MEM. PK CEM. 12/04/07 WINDSOR MILL, MD 21. Signature of Suneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD whiler the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, ck, or leart failure. List only one cause on each line. Immed te use (Final diseas condition resulting in death) Metastatic of the adenocarcinoma weeks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to turias a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 XER/Outpatient 3 □ DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760. as attending p the signed by t certificate has been si rector, page 2 should I funeral director, After this al or Attending P safter death. I Director: After t d in by the funera completely filled in by To the Hospital c within 24 hours aff To the Funeral D

Physician

/Medical

Examiner

Funeral Director

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Completed

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Examiner

Physician/Medical

Completed

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Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0036

State Registrar mo

35844

Randallstown

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

MO

November 28 2007

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D Roggen 5400 Old Count Road Suite 108

31. Date filed (Month, Day, Year) NOV 3 0 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 2007 RIDDICK **Physician** Edward AMES VOV /Medical 4a. Facility Name (If not institution, give street and number)
5726 SUGAR MAPLE 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK FROOTRICK 9. Birthplace (State or Foreign Country)

NORFOLK, VA. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 □ F Months 223-44-44/1 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No FREDERICK FREDERICK MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5726 SUGAR MAPLE 21703 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK altimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US GOVT. College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) COLLINS RIDDICK BEULAH JESSIL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MAPLE CT. FREDERICK MD 21703 5726 SUGAR RIDDICK ALICE NOV Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition GARRISON FORESTVET COM. 30,2007 OWINGS MILLS, MD. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. KOLLINS FUN. I ROME 21. Signature of Funeral Service License 110 WEST SOUTH ST FREDERICK MO 21701 say a. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or of shock, or head failure. List of Immediate Cause (Final disease or condition resulting in death) immediate Myocar Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, liarly local 1 immediates. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buris Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed caus ct Frederick of death (Item 23a) (Type, Print) 610 Solwex 1)2/2

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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30. Name an indiress of person who completed cause of death (Item 23a) (Type, Print) Johnson

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State Registrar 4000 old court Road Suite 301

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Balt more

Kalen F. Bellitt, N.D.

Karen L. Babitt, Mid.

31. Date filed (Month, Day, Year) NOV 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 25 ROSS 2007 9:25A GLORIA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RUXTON HEALTH & REHAB OF PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06/29/1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 🛣 F 79 132-20-9301 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6911 BLANCHE ROAD 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **ALEXANDER** ZICHLIN SADIE BAKAL SAMUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACK ZICHLIN / BROTHER 5901 TAYWOOD DRIVE, TAMPA, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG. 11/28/2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or combileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 Mouth Due to (or as a consequence of) TUMOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If ves, outcome pf pregnancy 23d. Date of delivery egnancy Day Year ecify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O.

or Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Physician/Medical

in the past 12 months? 1 Yes 2 No 9 Unknown	1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pro
	4.71. 47. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.	No. of the state o

decubitus

25. Was case referre examiner?	
27. Manner of Death	
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2 Accident	investig
3 ☐ Suicide	6 Could n

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

y jation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Signature	and	title	of	certi	fie
	- I 1				-	_

29a Certifier

29c. License number D25643 29d. Date signed (Month, Day, Year) 26

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV3 0

. R. Faulkner MD/ Was 5 N. Charles Street/ Suetz 209/Balto MD 21204 Resistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JOSE LUIS LUPEZ, M.D.

NOV 3 0 2007

31. Date filed (Month, Day, Year)

82. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. lent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year /Medical Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, last birthday) **Funeral** Days Min 1 M 2 □ F 8-42 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ahromeny injury or other traumatic auch. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND 10e. Steet and Number 10f. Zip Code 10g. Citizen of What Country? 2 Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 22 No Specify: Specify: 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ng most of working Elementary/Secondary (0-12) College (1-4or 5+) +HGRADE To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) -RANCIS Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MADISON THORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** n our /Medical Due to (or y a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine KNO to the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 Pregnant at time of death 5 Other (specify) al Unknown 9 Unknown signed by aditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 3 Probably 4 Unknown 1 ☐ Yes peeu Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2□ No 1 Tes 21 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 2 1 🗌 Yes 1 DInpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To tha Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed, (Month, Day

Registrar

State

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			1 - For State Registrar	or Mary		rtificate of	Death	, ,	eg. No 200	7 38310
	Physici		Decedent's Name (First, Middle, Last) Lu	icile E	Barcase	Shaw		2. Date of Deat Month Novembe	th Day Year er 27,2007	
	/Medic Examin		4a. Facility Name (If not institution, give street and Gilchrist Center	i number)			r Location of Death	_ No venao	4c. County of De	ath
	Funeral Director		5. Social Security Number 220-14-8192 Usual Residence of Decedent 6. Sex 1 □ M 2 Usual Residence of Decedent		yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	Nore Co. irthplace (State or Foreign Country) West Virginia
	the Maryland 28a-f show notified at	Director	10a. State 10b. County Maryland Baltimore 10e. Street and Number	100	c. City, Town or Le	ocation 10f. Zip Code	Colgat		0g. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2★→No Country?
2020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	Arme 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes	Decedent Ever d Forces? 'es 2 Mo s, Give or Dates:		1⊡Yes 2∏xNo	lispanic Origin? (Span, Mexican, Puerto Specify:		Black, Wh	nerican Indian, lite, etc. White
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, Mai	1 and 2 sho Health and I em 27 Is me		19a. Informant's Name/Relationship (Type. Print) Mr. Maxwell Shaw (Hus		1	ng Address <i>(Street</i> 3 Bank St			r, City or Town, State Maryland	
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do no	Examiner	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ě to (or as a cor e to (or as a cor e to (or as a cor	nsequence of):					
O. DOY 001	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	, outcome pf pr ive birth 2 regnant at time Inknown	Fetal death 3	□Ectopic pregnanc	,		23d. Date of d Month	lelivery Day Year
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	viti Con	2	29b. Signature and title of certifier			D S	7303	2	Date signed (Mo	nth, Day, Year)
	<i>v</i>		30. Name and address of person who completed	cause of death	(Item 23a) (Type	Print)	TOUSON	no zi	2020	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 3 0 2007	2 Aegistrar's S	Signature	artis				as stated. ue to the cause(s) nth, Day, Year) 27 2007

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

SPring mann

Funeral Director

Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a er death.

To the Funeral Lirector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, State Registrar

Registrar				Ceri	illicate of t	Jeam		R	eg. No.	IIIIIII	37	331
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4a. Facility Name (If not					4b. City, Town, o					CTIV		ص
FRANKLIN 5. Social Security Numb	ber 6. Sex	HOSP17	HL Ce ge (In yrs. las	t birthday)	If Under 1 Year		24 Hrs.	8. Date of Birth		9. Birt	hplace (Sta	ate or Foreign
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8100 Rossvill	e Boulevaro	d			21236				U.S.A	١.		
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1 ☐ Never Married 3 ☐ Widowed 4 🎗		1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			□Yes 20X No	Specify		,		onifu:	nite	
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19a. Informant's Name Frederick			I .		altimore						zip Code)	
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23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approx Interva	timate I Between
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25. Was case referred	to medical					26 DI-	o of Dooth	1□ Yes	2 400	1 ☐ Ye	s 2 No)
examiner?	· Lu	ospital: 1 Inpat	ient 2 🗆 🗀	3/Outnation	3 DOA Oth	er.		(Check only on the 5 ☐ Resid		Other /Sa	acifu)	
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	6 Could not be determined	28e. Place of in	njury - At hom	e, farm, stre	et, factory, office		2	28f. Location (S	Street and N	lumber or F	ural Route	Number,
→ □1 ioillicide		building, 6	etc. (Specify)				10	City or Tow	, Utate)			
	Certifying Phys Medical Examin		of examinatio									use(s)
29b. Signature and jitte	e of pertifien	/			29c. Licens	e number		:	29d. Date s	igned (Mon	th, Day, Ye	ear)
11/1/	11/1/	LAM	' /N	17	100	63	159		11/2	8/05	7	
30. Name and add 988	s of person who cou	mpleted cause of	death (Item 2	3a) (Tyne I		01	111		11/2	0 -		
-	chanTiving				uare	Dri	12	Balti	MAC 2	m	2 0	1237
31. Date filed (Month,	Day, Year)	32. R gis	trar's Signatu		1 3-	VIII	_	~~~ · · · ·				
	10 V 3 0 21	007	was d	S A	DAME!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Many land alhimore 6. Sex If Under Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Months Min. Director 04 12 30 MD 213-28-9646 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Parkville MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1386 Deanwood Road 21234 U.S.A. 14. Race - American Indian, ral", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: 3√Widowed 4 □ Divorced Black Year or Dates: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital 12th grade <u>Nurse Technician</u> permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Minggie Carrie Burt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Sherrod-Son 1386 Deanwood Road, Parkville, Md 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 12/3/07 Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Signal ry of Funeral Service Licensee 21215 23a. P. 11. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immer late Cause (Final diser se or condition refulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): be executed Recipien F burial-trai Due to (or as a consequence of): physician Physician/Medical the requires that the death certificate as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has e 2 page al vascular certificate 2 No 1□ Yes 25. as case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the f 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760, o ۵ Records, or Vital To the Hospital or Attending Physician: Division 24 hours after within 24 hours a

To the Funeral I

completely filled i

State Registrar

chew 31. Date filed (Month, Day, Year)

30. Name and address of person who com-

29b. Signature and title of certifier

32, Registrar's Signature

se of death (Item 23a) (Type, Print)

0

29c. License number

DO0 57218

225 Green St

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 38313 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year NOVEMBER 28, 2007 **Physician** WILLIAM BERNARD SANDERS 2:45 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FUTURECARE CANTON HARBOR BALTIMORE N/A 8. Date of Birth (Month, Day, Year)
DEC. 28, 1922 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1X M 2□ F 219-10-0262 84 Director MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, it is Medical Examiner must be notified at 1XYes 2 No Director MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 S. HIGHLAND AVENUE 21224 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. XYes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: 1943-45 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry a filed within 7, at Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) MAINTENANCE OLD BAY LINE permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN W. SANDERS, JR. ပ MARY G. LAUGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET SANDERS/ WIFE 504 S. HIGHLAND AVENUE BALTIMORE MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST VA CEM. 12/4/07 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician purma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a Examine f any tracing to immedicause. Enter Underlying Cause (Disease or injury be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical The law requires that the death certificate use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No. the 9 Unknown 9 Unknown by 1 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by Fur Etit 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospitel or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဥ 2 No this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide hours after within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tie of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11.2807 24276 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMON SCALIA, M.D. 2801 HUDSON STREET, BALTIMORE, MARYLAND 21224 31. Date filed (Month, Day, Year) Registrar's Signature State Registra

1110 ld Edward [*]		1- For State Contificate of Death	883
Physicia al Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) RONALD EDWARD TOWSON, JR. 2. Date of Death Month Day Year November 25, 2007 0904 hrs	eath
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1314 Bedford Avenue Pikesville 4c. County of Death Baltimore County	
Funeral Director		5. Social Security Number 220-27-0042 1 Mm 2 F 17 Yrs. 7. Age (In yrs. last birthday) 17 Yrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Months Days Hours Min. 02/26/1990 Foreign MARYI	or LAND
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be patified at once.	To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes or Nolif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 19. White, etc. 19. White, etc. 19. Specify: BLACK 11. Yes 2 X No specify: 11. Yes 2 X No specify: 11. Yes 2 X No specify: 12. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Yes or Nolif Yes, Origin? (Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bift Yes, Origin? (Specify Yes or Nolif Yes or Nol	225 MD
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cian: The law requir certificate has been s ector, page 2 should b	Completed by	24a. Was an autopsy finding prior to completion of death? 1 V Yes 2 No 1 V Yes 2	
To the Hospital or Attending Physician: The law requirement 24 hours after death. To the Funeral Director: After this certificate has been stompletely filled in by the funeral director, page 2 should the	Certification: To Be	25. Was case referred to medical examiner? 1	mber, City
To the H within 24 To the Fr completel	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number O.C.M.E. November 26, 2007	r)
r	tate	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 17. 25 PM Verna May Valentine November 2007 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore St. Hospital 6. Sex Agnes 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/13/1943 **Funeral** 9. Birthplace (State or Foreign Days Months 1 ☐ M 2 🛛 F Yrs. 213-72-1791 64 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Director N/A Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Benson Avenue 21227 Funeral United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Valentine Helen D. Strumsky မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Sargent (Sister) 3204 Hideout Drive, Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial 12/01/2007 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hubbard Funeral Home, Inc. 11. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician 9 days right A cute disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Hupovolamia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Aspiration

Due to (or as a consequence of): attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown certificate has been s' rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 **X** No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo 1 Minpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural ours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 54996 27 2001 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Bichhuona 900 S. Vinh Catm 31. Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

07-08942	
Garrick Wesley	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

umak 1100.07		1- For State Certificate of Registrar Certificate of Registrar		Reg.	No. 200	7 3831
Physici ledical Exam				Date of Death Month November 1	Day Year	3. Time of Death 2123 hrs
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		Mercy Hospital	Baltimore		,	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	_	(MM/DD/YYYY) 9. Birt	
Director	į .	21766-2553 1X M 2 F 40 Yr	Months Days Hours Mir	6/28/	1967	untryMARYLAND
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imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental sant: If item 27 is marked or other traumatic event,	ř	DEBORAH MASSEY SYDNOR/MOTHER 4	ng Address (Street and Number or	CIRCLE,	PIKESVII	LE, MD
e, MD 1 and 2 shot Health and item 27 is rutraumatii		20a. Method of Disposition 20b. Place of Dispo	osition (Name of cemetery,		20c. Location - City or	
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Baltimore, permit. Pages 1 an Department of Hea Important: If itel			Name and Address of Facility H(OWELL FU	JNERAL HO	ME 21207
_ 21-1	_	Muxune (8 howy 4	600 LIBERTY HI	EIGHTS A	AVE, BALT	IMORE, MD
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D.O. Box 687 that the death certific ned by the attending i detached for use as ti	Physician	past 12 months? 4 Pregnant at time of death 5 0	Other (Specify)			
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Records, P.O. In the law requires that the law seen signed by the lage 2 should be detached.	Completed by	difference disconstruit		24a. Was ar		topsy findings available
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should t	힡			autopsy perform	ned? death?	completion of cause of
			26.Place of Death (Check	1 Yes 2	No 1 Y	es 2 No
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Vision of Vital F or Attending Physician: ther death. Director: After this certifi in by the funeral director,	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of		1	w injury occurred	
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		auoIZi	O.C.M.E.		November 19, 20	007
		30. Name and address of person who completed cause of death (Item 23a)				
10		44	Street, Baltimore, MD 2120)1		
S Regis	tate	31. Date filed (Months Day, Year) 0 2007 1	Could a			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 10:55 AM Florence Louise White 29 2007 Nov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital st. Agnes Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 05/26/1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 ☐ XF 92 Maryland 215-40-7667 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sh must be notified Director N/A 1XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1127 West Lombard Street 21223 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💆 No Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Webb Sadie Tuttle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Helmick (Daughter) P.O. Box 292 Davis, West Virginia 26260 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or Cedar Hill Cemetery 12/03/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee MarleT 23 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease are implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pneumonia MRSA 8 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-trai Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Vital Records, Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29c. License number 29b. Signature and title of certifier , MO Fare OP19513

29d. Date signed (Month, Day, Year) Nov 29, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haspital, 900 S. caton Avé, Baltimone, MO 21229 Fazeli, St. Agnes

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Florence

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			1 - For State Registrar	Claic of Wi	=	Certificate of De			Reg. No.	, ,	000	1 2
			Decedent's Name (First, Middle	, Last)				2. Date of Dea	ith		3. Time of I	Death
	Physici		Thelma Bernice Wilson-Carey				arey	Month 11	25 2	Year 007	2:05a	a M
7	/Medic Examin		4a. Facility Name (If not institution	give street and number)		4b. City, Town, or Lo	cation of Death		4c. County		1	
1		•	Manor Care N	ursing Hom	ne	Catonsv	Catonsville Baltim					
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birtho	Months Days	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or	Foreign
ы	Director		225-40-7558	1 M 2 A F	75 Yr	5.		05 04			VA	
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				1	Od. Inside City	y Limits
	f sho	ō	MD NA			timore				1	1X Yes	2 🗌 No
	the A	ect	10e, Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	trv?	
	With Ba or	١	3517 Holmes	Ave		2121	.7		U.	S.A.	•	
	death	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, I		ecify Yes or No-	14. Race		an Indian,	
9	or ite	Ē	1 Never Married 2 Marri	Armed Forces?	No	If Yes, specify Cuban, !		Hican, etc.)		c, White,		
03	72 hours after death with the Maryland netural', or Items 23a or 28e-f show dical Examinar must be notified at	1 by	3√ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		TE TES ALINO S	эр в спу.		Specity:	Bla	ack	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if health and Mental Hyglene. Item 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event. The Medical Examinar must be notified at	Completed	15. Decedent (Specify only highes		16a. D	ecedent's Usual Occupation Give kind of work done during fe. DO NOT use retired)	on ing most of work	ing	16b. Kind of Bu	siness/Ind	dustry	
121	within ene. than "i	mpl	Elementary/Secondary (0-12)	College (1-4or !	5+)				ц	ouse		
	liled v Tygie ther t	ပိ	12th grade 17. Father's Name (First, Middle,	na	į t.	lome Maker	Mother's Name	a /First Middle	Maiden Sumame		-	
Maryland	should be filed within and Mental Hygiene. s marked other than "umatic event, the Mag	Be.	Emmett Wilso			1	ith Cla			-,		
Z	should and Men marke umatic	은	19a. Informant's Name/Relations		19b. N	lailing Address (Street and			r. City or Town. S	State. Zip	Code)	
Ma	nd 2 sho lith and 27 is my treum		Jamaar Carey			7 Holmes A					217	
e,	thealth if		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other place)		Date	20c. Location - (City or To	wn, State	
30	Pages nent of I int: if ite		Nation 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from State	Garris	on Forest	Vet 12	2/4/07	Owing	s M:	ills,	Md
Baltimore,	가 다 라 하		21. Signature of Funeral Service		4	22. Name and Address of	of Facility					
ä	Departiment of the population		Thanno	n Hak	am!	larch F/H W	Vest	Raltin	ore. M	d	21215	
	77		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do no	enter the mode of dying, s	such as cardiac	or respiratory an	rest,		Approximate Interval Betw	veen
1	Physician		Immediate Cause (Final disease or condition	oy oo out o o out		ILCAL CA					Onset and D	
	/Medical		resulting in death)	Due to (or as	a consequence of)		11000					
	Examiner		Coquentially list conditions	b								
	թ : ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Uissass or injury	Due to (or as	a consequence of)							
	acute ind trans	am	that initiated events resulting in death) Last	c						1		
50,	cian a	Ω .	rosaning in dodain, East	Due to (or as	a consequence of)							
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical Examiner		d.						-		
	ding l		IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date	of doline	201	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date Mon			ear
0	y the d	Physician/	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown	a mile or down	one care (openity)						
σ.	es that the death cei igned by the attendir be detached for use	y Pt	Part II. Other significant condition	ns contributing to death b	out not resulting in t	ne underlying cause given i	in Part I.	23e. Did to	bacco use contr	bute to th	ne cause of de	eath?
rds	quires n sign	q p	ALZhen	ner's I	NZMZN	TIA		1 🗆 Y	'es 2□No	3 🗌 Prob	ably 4 🖽	nknown
00	w require s been si should b	Completed by						24a. Was a	an 24b. V	/ere auto	psy findings a mpletion of ca	ıvaılable
Re	9 L 0	mo						autop perfor 1 ☐ Yes	med? d	rior to coi eath? □ Yes		use of
ta	icien: Th certificate rector, pag	a	25. Was case referred to medical			26	6. Place of Deat	h (Check only o				
<u>></u>	Physicien: this certificatal director,	To B	examiner?	Hospital: 1 Inpatie	ent 2 ER/Outp	atient 3 DOA Other:	4 Nursing Ho	me 5 Resid	lence 6 Othe	r (Specify	v)	
0	ding Ph After th funeral		27. Manner of Death 1 Patural 5 Pendin	28a. Date of Inju	y Year) 28b. Tin	ne of 28c. Injury at			ow injury occurre			
0	Attending r death. ector: After by the fune	atlo	2 Accident investig	jation			s 2□No					
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could in determined	and 286, Place of In	ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (S City or Tow	Street and Numbe m, State)	er or Rura	l Route Numb	er,
0	urs af											
	Hospitel	edical			f examination and/	death occurred at the time, or investigation, in my opini						
	the the	Med	29b. Signature and title of certifier		atou.	29c. License no	umber		29d. Date signed	(Month,	Day, Year)	
5	To To			m D		2000	9107		_			
	0		30. Name and address of person		leath (Item 23a) (To	rpe. Print)	0 6.	150015	11-26 WN M		117	
	3		KALU UMA		1~855 CE		-0	NUVIV	wn in	D -	-1156	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	AP B						
	Registi		NUV S U Z	UU! Sales Sales Sales	10 Jag	and the state of t						

1 - For State Registra 1. Decedent's

Completed by Funeral Director

To Be

Examiner

Physician/Medical

Certification: To Be Completed by

Medical

Physician

/Medical

Examiner

Funeral

Director

	Please 1			Black Inde						egible.			
For State Registrar		State of I	viarylan	d / Depart <i>Certit</i>		f Health a of Death		rental Hy	ygiene Reg. No:	דחחק	38320		
1. Decedent's Name (/)		2. Date of D Month	3. Time of Death									
Alfred Joh			or)	41	City Town	n, or Location	of Death	Nov.	1	year 2007 County of De <i>a</i> t	11:15 A M		
Forest Hil						t Hill	or Death			rford	"		
5. Social Security Num			Age (In yrs.	last birthday) If	Under 1 Ye	ear If Under		8. Date of B		hplace (State or Foreign			
215-12-711	1	X M 2□F	93	Yrs. M	onths Da	ys Hours	Min.	MD					
Usual Residence of De 10a. State 16	ecedeпt 0b. County		10c. City	y, Town or Locati	on						10d. Inside City Limits		
MD N/A Baltimore											1 MayYes 2 □ No		
10e. Street and Number					10f. Zip Cod	ie			10g. Citiz	en of What Co	untry?		
723 Ponca	Street				2122	<u> </u>			USA				
11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 [12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? Ľ X No	If Ye	S Decedent es, specify (Yes 2 🟋	of Hispanic Or Cuban, Mexica No <i>Sp</i> ec <i>ity</i> :	in, Puerto	ecify Yes or N Rican, etc.)		4. Race - Amer Black, White Specify: Wh			
	5. Decedent's Edu			16a. Decedent	r's Usual Oc	ccupation			16b. Kin	d of Business/	Industry		
	only highest grad		or 5+)	(Give kind life. DO	d of work do NOT use re	one during mos tired)	st of work	ing					
12	4 48 4 8 4			Machin	e Ope		and a 8 * · ·	· /Fin / 44:		lehem S	Steel		
17. Father's Name (Fit							ers Name se Re	e (First, Middl ehak	e, waiden S	ourna m e)			
19a. Informant's Name		pe. Print)		19b. Mailing A	ddress (Str				ber, City or	Town, State, Z	Zip Code)		
Josephine 1	Wallner-	Wife		723 Po	nca S	treet	Ва	ltimor	e, MD	21224			
20a. Method of Dispos 1 ☑ Burial 2 ☐ 0		Removal from Sta	20b. F	Place of Disposition cemetery, cremate	on (Name of ory or other	f place)	[Date	20c. Loc	ation - City or	Town, State		
4 Donation 5	Other (Specify)			cred Hea						timore,			
21. Signature of Fund	ral Service Licens	see				ddress of Facili stern /				ler and MD 212	d Son, Inc.		
23a. Part1. Enter the	disease, o complailure. List only o	lications that cau	sed the deat	h. Do not enter t							Approximate Interval Between		
Immediate Cause (Fir disease or condition resulting in death)		a	spre	alu	. pi	uno	u s	<u></u>			Onset and Death		
roodining in dodain,		Due to (or	as a conseq	uence of):	0 -	unter							
Sequentially list condi	tions, ediate	b. Due to (or as a consequence of):											
cause. Enter Underlyi Cause (Disease or inju- that initiated events		с											
resulting in death) Las	st .	Due to (or as a consequence of):											
	•	d											
IF FEMALE: 23b. Was decedent print the past 12 months and 1 yes 2 N 9 Unknown	onths?		h 2 ∐ Feta it at time of d	aldeath 3□Ec	topic pregnather (specify	pic pregn <i>a</i> ncy					d. Date of delivery Month Day Year		
Part II. Other significa	ant conditions co	ntributing to deat	h but not res	ulting in the unde	rlying cause	given in Part	1.		d tobacco use contribute to the cause of death?				
								24a. Wa aut per 1⊡ Yes	opsy formed?	24b. Were au prior to death? 1 ☐ Yes	utopsy findings available completion of cause of		
25. Was case referred examiner?	_						e of Deat	h (Check only					
1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inp			3 DOA					□Other (Spe	cify)		
	5 Pending investigation	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time of Injury		Injury at Work? 1 ∐ Yes 2 ⊑		28d. Describe	e how injury	occurred			
2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, for building, etc. (Specify)										n (Street and Number or Rural Route Number, Town, State)			
	☐ Certifying Phy ☐ Medical Exam		is of examina										
29b. Signature and titl	le of certifier				29c. Lic	cense number			29d. Date	e signed (Mont	h, Day, Year)		
1	1 -				15	3			\sim	L _	2) 2007		

State Registrar

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31. Date filed (Month, Day, Year)
NOV 3 0 2007

DAVID

5

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WMCDAA

Rd. BELAIN Fiel 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:SJAM Eileen Akers Gertrude 4c. County of Death /Medical lovember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lions Center for Extended Care Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 27, 19 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Director 215-20-6470 81 1926 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 N. Mechanic St. Apt. 1002 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ XNo þ Specify: 3 ₩ Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is ma ked oth Be Charles H. Johnson Catherine Elizabeth (Martin) Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Helman Drive MD 21502 Anna Garlitz daughter LaVale 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If II any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 11/23/2007 4 ☐ Donation _5 ☐ Other (Specify) MD Cresaptown 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23. Fair. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) rate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 일 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at . Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

Division or Vital Records, P.O. Box 68760, within 24 hours a completely

DHMH 17 Rev 1/2001

State Registrar Bishop

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harit Srlh

31. Date filed (Month, Day, Year)

NOVEMBEL 23 2003

umberland MD 21503

Registrar

07-08701

Delonte Marvin Brooks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 38323

		- For State legistrar		Certific	ate of	Death				g. No.		
Physiciar edical Examin	1/	Delonte Marvin Brooks Novemb									'ear	3. Time of Death 0120 hrs
	4	4a. Facility Name (if not institution, West Street at Lee Stre		r)	41	b. City, Town, o Annapolis	r Location of	Death			ty of Death Arundel	1
Funeral Director			Months Days Hours Min									
215-0036 be filed within 72 hours after death with 1 mial Hygiene. rked other than "natural", or items 23; erit, the Medical Examiner must be no	To Be Completed by Funeral Director	10e. Street and Number 3155 Beaver 11. Marital Status 1 X Never Married 2 Mar	12. Was Deceder Armed Forces 1 Yes red If Yes, Give Year or Dates: fy only highest grade co College (1-4 o Brook p (Type, Print) oks/mothe 3 Removal from S acity:	nt Ever in U.S. ?? 22x No completed) 16a r 5+) C R .S 1 20b. Place crem	13. Was If Ye 1 . Decedent during mc ustole epre	ake Be 10f. Zip Code 207 s Decedent of H ss, specify Cubs Yes 2 X N 's Usual Occup sst of working lif mer Se sentat Address (Str Beave tition (Name of orer place) e Jore	32 Ispanic Original, Mexican, Ispanic Original, Mexican, Ispanic Original, Mexican, Ispanic Specify: ation (Give kive. DO NOT to the companies of the companie	Puerto Rici	ify Yes or Nocan, etc.) k done ify irist, Middle, if a a a Route Nun a d Ch Date	Special 16b. Kind of Med Macka Macka nber, City or Tes. B. 20c. Location	SA ace - Amerinite, etc. fy: B1 Business/ i ca1 me) 11 Town, State ch., on - City on	ican Indian, Black, a c k Industry e, Zip Code) MD 20732 r Town, State h . , MD
Physician /Modical kaminer		221. Signature of Funeral Service Licensee ### Apart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 22. Name and Address of Facility Sewell Funeral 1451 Dares Beach Rd. Prince Funeral 1451 Dares Beach Rd. Prince Funeral 1451 Dares Beach Rd. Prince Funeral 1451 Dares Beach Rd. Prince Funeral 1451 Dares Beach Rd. Prince Funeral 1451 Dares Beach Rd. Prince Funeral Prince Prin										Approximate Interval Between Onset and Death
cuted nd transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a corduction of the corduction of	ar L								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	nysician/I		1 Live birth 4 Pregnant nown g Unknown	at time of death	2 Fe	her (Specify)		c pregnanc		Mont		Day Year
ords, P.O. Box 68 w requires that the death cert as been signed by the attendir should be detached for use a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death. 1 Yes 2 No 3 Probably 4 Unknow 24a. Was an autopsy Probably 4 Unknow 24b. Were autopsy findings avail prior to completion of cause			autopsy findings available completion of cause of
Vital Reco hysician: The law this certificate has	Com					ac Die	ace of Death	(Chack or	1 Yes	ormed? 2 No	death?	
/ital	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2 ER	/Outpatient		Other ₄		Home 5	Residence	6 🗸 Oth	er: Scene
n of Vital Recing Physician: The l	⊢ t	27. Manner of Death	28a. Date of I (Month, Da Nov 9, 200	njury 28	b. Time of I	injury 28c. li	njury at Work	. lp		how injury of auto fixed		collision
Division of Vital Records, To the Hospital or Attending Physician: The law requirements to the Funeral Director: After this certificate has been strompletely filled in by the funeral director, page 2 should be	Certification:	Nov 9, 2007 0120 hrs 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29 determined 4 Homicide (Specify) Local Street								(Street and N State) at Lee Stree		Rural Route Number, City olis, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	4 Homicide 29a. Certifier (Check only one) 2 Medical Example 1	ysician: To the best of niner: On the basis of e and manner state	f my knowledge, examination and/o	death occu or investiga	rred at the time tion, in my opin	, date and plaining, death or	ace, and d	the time, date	use(s) and ma e and place, a	nner as stand due to	ated. the cause(s)
E 3 E 8	Me	29b. Signature and title of certifier	r				ense number C.M.E.				signed (M	donth, Day,Year)
w 3		30. Name and address of person Donna M. Vincenti, MI				1 Penn Stre	et, Baltim	ore, ME	21201			
Sta	ate	31. Date filed (Month Day Year)	4 2007 32. R	trar's Signature	4	all					-	
Regist	ıdı	<u> </u>	W. march	Who was a free	A CO POR							

			For State Registrar	State	of Maryla		artment of H rtificate of I		d Mental Hy	giene 20	07	38324	
ς.			Decedent's Name (First, Middle	e, Last)			inouto or i		2. Date of De			3. Time of Death	
	Physici		Christian	Z•	By1e	er			Month	Day	Year	11:10 PM	
	/Medio		4a. Facility Name (If not institution	n, give street and nu			4b. City, Town, or	Location of D		r 18, 2007	f Death		
	LXAIIII	ie i	9830 N. Ryceville		,		Mech	anicsvi1	110			l. a	
	Funeral		5. Social Security Number	s. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	9. Birthp	lace (State or Foreign			
n	Director		220-44-7944	1 ⊠ M 2□ F	85	Yrs.	Months Days	Hours N	Min. (Month, Da	ay, <i>Year)</i> er 19 . 1922	Coun	itry)	
office	-		Usual Residence of Decedent						Берсешье	21 19,1924	ren	nsylvania	
	ylan yow at		10a. State 10b. County		10c. C	City, Town or Lo	ocation				1	0d. Inside City Limits	
	Mar a-f sl	ż	Maryland St. 1	Mary's			Mecha	nicsvill	e			1 ☐ Yes 2 ☑ No	
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	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	11. Marital Status		edent Ever in	U.S. 13.	Was Decedent of H	spanic Origin	? (Specify Yes or No Puerto Rican, etc.)		- Americ	an Indian,	
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8	al", c	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I			1 ☐ Yes 2 ☑ No	Specify:		Specify:	WI	nite	
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þ	al Hy loth	Be (17. Father's Name (First, Middle,	Last)			İ	18. Mother's	Name (First, Middle	, Maiden Surname)		
<u>a</u>	uld b Ment Irked Itic e	횬	Benjamin Z. Byler					Mary Z	look				
Maryland	sho and I s ma	Ì	19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street a	and Number o	or Rural Route Numb	er, City or Town, S	tate, Zip	Code)	
Σ	and 2 salth 27 i	1	Susie Stolfzfus By	ler / Wife		9830	N. Ryceville	e Road	Mechanicsv	ille, MD 20	659		
ore.	of He		20a. Method of Disposition	• T.D	I .	Place of Dispo	osition (Name of matory or other place	e) ! N	Date	20c. Location - C	ity or To	wn, State	
Ĕ	Page Tent Int: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				Iill Cemeter	' NO	vember 21, 2007	Mechanicsv	ille,	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service	Licensee /			2. Name and Addres	s of Facility	1779				
Ö	any any any any any any any any any any		The school New	a Darde	mer		Mattingley P.O. Box 27	-Gardine	r Funeral Ho nardtown, MD	ome, P.A.			
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×	certif	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome pf preg	nancv		IYA	_	L 22d Date	of dolive	INA-	
Вох	eath atter for u	Sian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2□Fe nant at time of	tal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/ 60		23d. Date Mont		Day Year	
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	The law requires that the death certificate has been signed by the attending I sage 2 should be detached for use as	윤	Part II. Other significant condition	ons contributing to o	leath but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contrib	oute to th	ne cause of death?	
Vital Records,	sign d be	d by	Africal I	Forille	P.M				10			ably 4 ⊡Unknown	
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<u>si</u>	eath.	Certification:	2 ☐ Accident investig	gation	14		10	res 2 □ No		7-03	/		
≅	ter de irect irect	ξį	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	inod 28e. Place	e of injury - At liing, etc. <i>(Spe</i> c	home, farm, str cify)	eet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rura	I Route Number,	
	ital c irs af ral D led ii	Ö			N					7			
	Hosp 4 hou Fune ely fii	ca	29a. Certifier 1 Certifyir (Check only 2 Medical	ig Physician: To th Examiner: On the l	e best of my kr basis of examin	nowledge, deat nation and/or in	h occurred at the tin	ne, date and pointion, death of	place, and due to the occurred at the time,	cause(s) and man	ner as st	ated.	
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	one)		ner stated.								
	7 with 00 00 00 00 00 00 00 00 00 00 00 00 00	2	29b. Signature and title of cortific	164			29c. License	_	Q. M.C	29d. Date signed	(Month, i	Day, Year)	
)			- Congression	العراك	-		1700	3722	DURIC	11/19	14		
			30. Name and address of person	who completed cau	se of death (Ite	em 23a) (Type,			ferty, D.O.				
_			22333 Greenview				A Gr	eat M:	ills, MD	20634			
	Sta		31. Date filed (Month, Pay Year)	32.	Registrar's Sign	nature							
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DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 7 3 8 3 2 5												
	1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death												
Physicia	n								Month	Day			
/Medica	al .	James Edward B: 4a. Facility Name (If not institution				4b, City, Town, o	r Location of		Octobe		2007 County of Dea	7:45	P ^M
Examine	r	Union Hospital	, give an oot and in	mileory			ton				Ceci		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		4 Hrs. 8	8. Date of Bi (Month, D	rth av. Year)	9. Bi	rthplace (State o	r Foreign
Director		212-38-0714	1 X M 2□ F	66	Yrs.	Worth's Days	Tiodis		Jan. 2	7, 19		ryland	
and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside Cit	ty Limits
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with the Maryland a or 28a-f show t be notified at	Director	10e. Street and Number	JCC11		cii ba	10f. Zip Code				10g. Citiz	zen of What C	country?	
23a cust be		282 Old Bayviev	v Road			219					USA		
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Spec Puerto R	cify Yes or Natican, etc.)	0- 1	14. Race - Am Black, Wh		
rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	ied 1 1 Yes If Yes, G Year or I			1 ☐ Yes 2 🔀 No	Specify:				Specify:	White	
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be fill H ad oth	Be	17. Father's Name (First, Middle,							(First, Middle		Surname)		
hould nd Me marke	ှ	James Edward B		•	19b. Mailir	ng Address (Street			Garr Route Numi		r Town, State,	Zip Code)	
nd 2 sulth an ulth an 27 ls		Kim Murray/Daus				Old Bayv							
of Hee		20a. Method of Disposition		20b. F		osition (Name of matory or other pla		Da				r Town, State	
Page nent c int: If ury or		1 XBurial 2 □ Cremation 4 □ Donation 5 □ Other (S		n State		t Method:	1	m. 1	0/24/2	007 1	North I	East, MD	1
permit. Pages 1 and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bonce.		21. Signature of Funeral Service	Licensee	7 1		2. Name and Addre							
402.60		23a, Part 1. Enter the disease, or	complications that	caused the deat		11 S. Que					n, MD	Approximate	e
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Physician /Medical		disease or condition resulting in death)	aDue to	o (or as a conseq	uence of): U	yocontio	C in	por	Chor	-			-
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of d		Other (specify)					Month	Day `	Year
hat the deby detack	F	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did	tobacco u	se contribute	to the cause of d	ieath?
uires l signe Id be									1 🗆	Yes 2[□ No 3□	Probably 4 🗇	nknown
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The la te has age 2	E O								aute per 1∐ Yes	opsy formed? 2□Mo	death'	completion of c es 2 □ No	ause of
ian: rtifica	BeC	25. Was case referred to medica examiner?	1				26. Place	of Death	(Check only				
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death ctor: /	icati	2 ☐ Accident investignment in	not be	ce of injury - At he	ome, farm, sti	reet, factory, office	Yes 2 N		8f. Location	(Street and	d Number or i	Rural Route Nurr	nber,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0110 AM BLANCHE ELIZABETH BRUCE **NOVEMBER 13** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER HOSPITAL CHESTERTOWN 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🗶 F Months Days Director 154-36-0919 94 JULY 27, 1913 **NEW JERSEY** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified 1 ☐ Yes 2 No Director MARYLAND QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ıral", or items 23a or I Examiner must be r 835 OYSTER COVE DRIVE 21638 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian Black, White, etc. after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 72 hours 3 Widowed 4 □ Divorced Year or Dates: "natural" Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within the sith and Mental Hygiene. Item 27 is marked other than HOMEMAKER 10 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 JOHN CONNET PRICE ALICE BERTHA VAN DEVENTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA SHEPPARD KALDOR/DAUGHTER 835 OYSTER COVE DRIVE, GRASONVILLE, MARYLAND 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite NOVEMBER 15 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION STEVENSVILLE, MARYLAND 2007 21. Signature of Euneral Scale Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EREBROMSCULAR disease or condition resulting in death) week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of). Box 68760. physician Physician/Medical the as attending IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No for Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Linknown 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has autopsy performed certificate 2 No 1□ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA this After th funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) death. 1 Yes 2 No Funeral Director: tely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

within 24 To the (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Speci

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 5 200

DHMH 17 Rev 1/2001

Chestatown, MD 21620

32. Registrar's Signature

29c. License number D 0041587

Helena

29d. Date signed (Month, Day, Year) Ü

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

KATYM

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11350 Pembrooke Sq

mpleted cause of death (Item 23a) (Type, Print)

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			State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	ertment of Health Artificate of Deat		ıl Hygier Reg. 1		
	Physicia	200	1. Decedent's Name (First, Middle, Last)		Mo	e of Death	ZUU/	3. Time o Death 2
	Physicia /Medic		WALTER W BAKER	4b. City, Town, or Location		ember	15, 2007 4c. County of Death	11:05 PM
)	Examin	er	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital	Frederick			Frederic	k
	Funeral Director		5. Social Security Number 227-24-9614 6. Sex 1 M 2 □ F 82 Yrs.	Months Days Hours	rs Min. (Mo	e of Birth Inth, Day, Yea pt. 5	9. Birthp	olace (State or Foreign orginia
	Aaryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Md. Frederick Mount	ocation Airy			1	0d. Inside City Limits 1 Yes 2 No
	with the Raa or 28a-	I Director	10e. Street and Number 703 Prospect Road	10f. Zip Code	1771	10g. (Citizen of What Coun	
350	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 No Speci		s or No- etc.)	14. Race - Americ Black, White, Specify:	
215-0036	hin 72 hou e. In "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed] [Giv Gi	edent's Usual Occupation e kind of work done during rr DO NOT use retired)		16b.	Kind of Business/Ind	
7	ed witt ygiene ier tha	Com	8 0	Custodian Mana			Public So	chools
ana	d be fill ental H ced oth	Be	17. Father's Name (First, Middle, Last) Raymond Baker		other's Name <i>(First,</i> Aman da	(Unkno		
Mary	nd 2 shoul	<u>م</u>		ling Address <i>(Street and Nur</i> 03 Prospect Ro				771
more,	Pages 1 ar ent of Hea nt: If item 3		1 Bunal 2 Cremation 3 Hemoval from State	position (Name of ematory or other place) 1 Cemetery	Date 11/20/0		Location - City or To	
baitimoi	permit. Departm Importar any Inju			22. Name and Address of Fa Muriel H. Ba P. O. Box	acility arber Fun	eral H	ome	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,	nter the mode of dying, such	as cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
,00,00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):					
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as, r.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Pa	art I. 23		o use contribute to th	
al Records	: The law recate has bee	Completed				a. Was an autopsy performed Yes	prior to cor death?	psy findings available mpletion of cause of 2□ No
NI S	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Othor	lace of Death (Chec			
on or	ding Physician: The lav n. After this certificate has funeral director, page 2	ion: To	27. Manner of Death Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at	28d. De		6 □Other (Specifinity occurred	ν)
DIVISION OF	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		28f. Loc	cation (Street y or Town, St	and Number or Rure ate)	il Route Number,
	e Hospita 24 hours e Funera letely filler	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, derivation of the basis of examination and/or and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License numbe	er	29d. I	Date signed (Month,	Day, Year)
	_		MD MD	D0060	417	11-	-16-20	707
1			30. Name and address of person who completed cause of death (Item 23a) (Type Hemen Shah MD, 65-C Thame	s Tohnson	Dr. F	reder	NEK MD	21702
ľ	Sta Registr	te	30. Name and address of person who completed cause of death (Item 23a) (Type Hemen Shah MD 65-C Thomas 31. Date filed (Month, Day, Year) 32. Registra's Signature NOV 1 9 2007 Market M	Sparke	(

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Carrie Michele Bishop Vovember 19, 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13849 Dry Run Road Clear Spring, Washington Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 216-80-1256 1 ☐ M 2 🎖 F 46 MD **Director** Feb 23, 1961 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Modical Examinar must be notified at MD Washington Clear Spring, 1 Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13849 Dry Run Road 21722 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 27 Married SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. christian academy Elementary/Secondary (0-12) College (1-4or 5+) teacher 12th grade permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is markad othing any lipiry or other traumatic event otte. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. Crum Joan G. Seaman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) G.Steven Bishop spouse 13849 Dry Run Rd. Clear Spring, MD 21722 20b. Place of Disposition (Name of cometery, crematory or other place)
GreenLawn Cemetery Nov 26, 20c. Location - City or Town, State 20a. Method of Disposition Williamsport MD 1 SpBurial 2 ☐ Cremation 3 ☐ Removal from State 2007 ° 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc auxen P.O.BOX 310 Clear Spring, MD 21722 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Cama 53 month /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2X No 3 Probably 4 Unknown 1 Tyes Completed peen 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: No. Residence 6 Other (Specify) 3□ DOA Medical Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 5 Pending investigation Injury Natural 1 TYes 2 No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) tagerstown, no 21740 M JH-10 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After

State Registrar

31. Date filed (Month, Day, Year) NOV 1 5 2007

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

Medical



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DMILES

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

0 veryper 11200]

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38331 State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Janice Brown 11 2:43am M 12 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Hebrew Home Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07/21/43 Birthplace (State or Foreign Country) 1 □ M 2 F 64 578-58-8661 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Md Prince George 1⊠Yes 2□No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15609 Everglade Lane#201 20716 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify. 3 ☐ Widowed 4 M Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Immigration Officer Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Reid Ruby Choate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Scales Daughter 15310 Jenning Lane Bowie Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 11/17/07 Landover, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Mitchellville, Md

Physician /Medical Examiner

and

attending physician

ed by the a

Il Director: After this ad in by the funeral d death.

within 24 hours a To the Funerel (

Physician

/Medical

Examiner

Director

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Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "naturet", or ferms 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be matified as once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

29b. Signature and little of certifier

ALLEN

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRITHER M.D.

NOV 1 5 2007

23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dear	th. Do not enter the m	ode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS			-	Onset and Death
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregni 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco u 1 🗆 Yes 2	se contribute to the cause of death?
HIP FRACTURE				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26 Place of De	ath (Check only one)	
exammer? 1 2 Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatient 3 1	Other	Home 5 Residence 6	G ☐ Other (Specify)
27. Manner of Death 1 □ Natural 5 □ Pending 2 ☑ Accident investigation	28a. Date of Injury (Month, Day Year) 10-15- 2007	28b. Time of Injury	28d. Describe how injury	/ occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	Assited Li	•	City or Town, State)	ROPTON, MARYLAND
29a. Certifier 1 Certifying Phy (Check only 2 Medical Exemione)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occ	e and due to the cause(s)	and manner as stated. place, and due to the cause(s)

29c. License number

D-25914

POCKULLE, PRACTIPIO

29d. Date signed (Month, Day, Year) 11-14-2007

208 2

State Registrar 6121 HOUTESE RO

Jistrar's Signature

			For State Registrar	State	of Marylar		artment				lental		-201	07	38332
			Decedent's Name (First, Midd	lle, Last)			moure	0, 1	Journ		2. Date		. No. U		3. Time of Death
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	/Medi Examir		4a. Fecility Name (If not institution		umber)		4h City	Town or	Location of		Nove	MDET	4c. County		0:101
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under		If Under	24 Hrs.	8. Date	of Birth	rionicg		
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	ylan		10a. State 10b. County		1	ty, Town or Lo								1	0d. Inside City Limits
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	ltams	Funerai	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	cify Yes	- 1	14. Rac	e - Americ	an Indian,
9	or Ite	2	1 ☐ Never Married 2 🔀 Mar	ned 1 Tyes	2 TXNo	1				i, Pueno	Hican, etc	-)		ck, White,	
93	rei'.	by	3 Widowed 4 Divorced	If Yes, G Year or	Dates:		1 □ Yes 2	NO TYL	Specify:				Specify	Wh:	Lte
5-0	be filed within 72 hours after death with the Maryland nat Hyglene. ed other then "naturel", or Itams 23e or 28e-f show event, I're Medical Exaciling must be rotified at	Completed		nt's Education)	16a. Deced	lent's Usua kind of won	l Occupa	tion	t of worki	na	16	b. Kind of B	usiness/Inc	dustry
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2	e filed within I Hygiene. other than	5	7			Owner	<u> </u>						Clothi	ng Re	etail
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yla	should be nd Mental marked o	ဂ္	Harry Neibarth						Guss	ie S	torc	n			
Maryland 21215-0036	and and is me		19a. Informant's Name/Relations										ity or Town,		
≥ `	and paith n 27 er tr		Michael Barth -	Son					Road	. NW	Wash:	ingto	on DC	20015	5
ore	of He		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation	2 🔻	20b. F	Place of Dispo	sition (Nam	e of her place)	D	ate	200	c. Location -	City or To	wn, State
Ĕ	Pag ment ant: I		4 Donation 5 Other (5		l'State l'em	ple Bei Ceme	tery		' ! !	11/1	6/20) 7 V	Vhites	boro	NY
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other treumatic e once.		21. Signature of Funeral Service	Licensee	-	22	Name and	d Address	s of Facilit	у	M	1	O1	1 - T	_
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н			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that	caused the deat	h. Do not ente	er the mode	of dying	, such as	cardiac o	r respirati	ory arrest	,		Approximate Interval Between
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Box	death certific e ettending p d for use as	Z/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pregna	ancy	C-+:-						23d. Dat	e of delive	ry
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ğ	w require been sig should b	ed	<u> </u>	RTENSI	ON							1 🗌 Yes	2 100	3 ☐ Prob	ably 4 Unknown
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Division of	Phys ar this aral di		27. Manner of Death		of Injury oth, Day Year)	28b. Time of		C. Injury					e 6 □Oth		"
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á	after after Direct d in by	Certification:	4 Homicide determ	build	ling, etc. (Specif	y)	,,					r Tòwn, S			
	To the Hospital or Attending Pr within 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral		29a. Certifier 1 Certifyir	ng Physician: To the	e best of my kno	wledge, death	occurred a	t the time	, date an	d place, a	nd due to	the caus	e(s) and ma	nner as st	ated.
	ne Hk	edical	(Check only 2 Medical one)	CABITUTION OF THE	pasis of examina iner stated.	tion and/or inv	estigation, i	in my opi	nion, deal	h occurre	d at the t	me, date	and place,	and due to	the cause(s)
	Vithir To th	Me	29b. Signature and title of certifie	7			29c.	License	number			29p.	Date signed	d (Month, i	Day, Year)
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_	3		30 Name and address of perseq	who completed cau	se of death (Item	23a) (Type 5	Print\		100	0		100	0000	IDUN	1/2007
			DINESH P	ATEL 11.	1.612	(M.Da	Tres	e i	21).	Kaa	KUCL	CE.	Nes >	BR	14,2007
46	Sta	te	31. Date filed (Month, Day, Year)	320	Registrar's Signa	ture			1			7	, ,	0 00	
ŧ.	Registra		NUV 15	2007	ever l	K April	els)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gustavo Adolf Benavides State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Gustavo Adolfo Benavides Month Day Year November 20, 2007 **Medical Examiner** 0540 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 24113 Bush Hill Road Gaithersburg Montgomery 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24Hrs Funeral 43 Days 2/10/1964 229-43-4814 Months Min Foreign EcountSalvador Director 1 X Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Gaithersburg Montgomery 1 Yes 2 X No death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 20882 El Salvador 24113 Bush Hill Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Yes 2X No El Salvadoren White If Yes, Give Year 1X Yes 3 Widowed 4 Divorced No specify Specify. þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n College (1-4 or 5+) Contrctor Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilberto Benavides Berta Castellon Be 19a. Informant's Name/Relationship (Type, Print)
Silvia Benavides/Wife ress (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bush Hill Road Gaithersburg, Md20882 item . 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Important: If it All Souls Cem. 1 X Burial 2 Cremation 11/24/2007 Germantown,Md 5 Other Sc Donatio 21. Signature Funeral Service PHILTPOOR RIWALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Upper wastrointestinal henorrhan Immediate Cause (Final disease a. caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68/60, The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED #23a_PTT attending physician or use as the burial 27 perME_0874_12/3/07_TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Isoproponal use: fatty metamorphosis of the liver Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No No 1 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other; Nursing Home 5 Residence 6 ✔ Other: Scene this inpatient 2 ER/Outpatient 3 DOA 1 Yes ٩ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural neral Director: Yes 2 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year 32. R istrar's Signature

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Funeral Director				yrs. last birthda 18	y) If Under 1 Ye Months Da		8. Date of Bir	th(MM/DD/YYYY) 9. Bir 25 1989 Co	thplace (State or In West ^{untry)} Germany
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hryland Sa-f sho	Director	10e. Street and Number		Garena	10f. Zip Code		1	0g. Citizen of What Cour	1 Yes 2 X No
Vith the Maryl s 23a or 28a-		12749 Irelands			216			U.S.A.	
Baltimore, MD 21215-0036 Baltimore, MD 21215-0036 Equal: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 X		 Was Decedent of F If Yes, specify Cub. 	lispanic Origin? (Sp an, Mexican, Puerto		White, etc.	can Indian, Black,
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MD 2 2 shoul th and M 27 is m umatic	2	19a. Informant's Name/Relationship (Ronald Cole	(father)		3098 Ral			nber, City or Town, State stertown ,	MD, 21620
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Division of Vital Records, P.O. Box 68760, To the Hospital or Atracting Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year
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Divisior To the Hospital or Attentivithin 24 hours after death To the Funeral Director:	Medical Co	29a. Certifier 1 Certifying Physic	r:On the best of my kr	owledge, death	occurred at the time, stigation, in my opini	date and place, and on, death occurred a	due to the caus	se(s) and manner as stat	ted.
To To con	Me	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)
		30. Name and address of person who	completed cause of doct	(Item 23a)	0.0	C.M.E. 		November 19, 2	007
	_	Ana Rubio MD. Assista	nt Medical Examin	er 111 Pe	nn Street, Baltir	nore, MD 2120	1		
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Régistrar's S	Signature	Coartes				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Reginald Walter Cooper 9:59 A. M 2007 November 18, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/18/2007 Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 10 1**∑**M 2□F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show must. If Item 27 is marked other than "natural", or items be notifited at ury or other traumatic event, the Medical Examiner must be notifited at 10c. City, Town or Location 10a State 10b Counts 10d. Inside City Limits 1 ☐ Yes 2√ No Director MD St. Mary's **Hollywood** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25156 Morgan Road 20636 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Tes 27 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jenelle Lynn Price William Michael Cooper 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25156 Morgan Road, Hollywood, Maryland 20636 Mike Cooper (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/21/2007 Worton, Maryland Union Cemetery 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licens P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** extreme Fren disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has briector, page 2 s autopsy performed 1∐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20619 30. Name and ad vest of person who completed cause of death (Item 23a) (Type, Print) Joseph R. Tiralla, MD 110 Hospital Rd; Suite 202, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra Signature State NOV 2007 Registrar

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В	Physici	an	1. Decedent's Name (First, Middle, Andrew Michae					2. Date of De Month	eath Day Der 18,	Year	3. Time of Death
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ev- Armed Forces? d 1 ☐ Yes 2 No If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	E	Race - Americ Black, White, or Coify: White	etc.
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			For	State of Maryland / I			ntal Hygien	בחחל.	38337
			State Registrar Decedent's Name (First, Middle, Last)		Certificate of		Reg. N	19-001	3. Time of Death
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	/Medio Examin		4a. Facility Name (Innot institution give	street and number)		r Location of Death	4	c. County of Deat	
			5. Social Security Number 6. Sec		nter (r)nce	If Under 24 Hrs. 8	Date of Birth	9. Birt	hplace (State or Foreign
В	Funeral Director			100	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Yea	1939 ma	hplace (State or Foreign untry)
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	or 28s	Director	10e. Street and Number		10f. Zip Code	3 <u>2</u>	1 .	Citizen of What Co	untry?
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Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr Once.		21. Signature of Funeral Service Licens	mo1358	22. Name and Addre	iss of Facility ifts Registi nelley Dri	ry Hanover.	MD 2107	6
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do ne cause on each line.	not enter the mode of dyir	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
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ord	w requires that been signed k should be deta						1 🗆 Yes		obably 4 hknown
of Vital Records,	e la has je 2	Completed					24a. Was an autopsy performed	?_ prior to death?	utopsy findings available completion of cause of
ital	icien: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Death (1 □ Yes 2 2 1 Check only one)	No 1 ☐ Yes	2 No
of V	8 s :E	To B	T Tes 212 No	Hospital: 1 Inpatient 2 ER/C	outpatient 3 DOA	Nursing Home	5 Residence		cify)
on (fter fter	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of fnjury (Month, Day Year) 28b.	. Time of 28c. Injury Wo 1 □	rk?]Yes 2 □No	d. Describe now ii	nary occurred	
Division	spital or Attendi ours after death. ieral Director: A filled in by the fi	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28	f. Location (Street City or Town, St		ural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Co	29a. Certifier Check only one) Certifying Phy	rsicien: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurred at the ti and/or investigation, in my o	me, date and place, and opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of dertifier	and manner stated.	29c. Licens	se number	29d.	Date signed (Mont	h, Day, Year)
			· / mn	1	100	61941		114/0-	7
76A)	1		30. Name and address of person who a Mano's Mathur, M	I.D. 110 Hospital	Rd. Ste 30	5 Prince F	rederick	C. M.D. 50	1678
47°	Sta		31. Date filed (Month, Day, Year) 1	4 2007	k 1 10	- 1111101		-1	<u> </u>
	Regist	rar		THE PERSONAL PROPERTY OF THE PERSONAL PROPERTY	1. Aprile	0			

SP Living

JOSEPH CULLISON

State Registrar DAVID FEDERLE HOL

31. Date filed (Month, Day, Year)

NOV 2 0 2067

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			For	State	of Maryla	nd / Depa	artment	of Hea	alth and	-	Hygie	ne		0010
			1 - State Registrar			Ce	rtificate	of De	eath			No200		8340
	Physici	an	Decedent's Name (First, Midd	le, Last)						Mont		Day Ye	er .	ime of Death
	/Medic	al	Mary Roy 4a. Facility Name (If not instituted)	ve Couchma	an		4b. City, To	uen orlo	antion of D			r 15 20	07	11:25p™
	Examin	er	Somerford Place			ro Pik	-		gerst			Washin		County
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	Year II	f Under 24 l		of Birth th, Day, Ye			State or Foreign
	Director		220-09-9603	1 □ M 2 🕅 F	86	Yrs.	Months (Days	Hours N	vin. (Mon Feb	16 1	921	Maı	ryland
	D .		Usual Residence of Decedent 10a. State 10b. Count	4	10c C	ty. Town or Lo	nation						104 100	side City Limits
	sho	5		v Vashingtor		Hagers								Yes 2\ No
	the A	Director	10e, Street and Number				10f. Zip C	ode			10a.	Citizen of Wha	t Country?	
	3a or	0	10116 Sharpsl	nuro Pike					740			U.S		
	death	nera	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Deceder			? (Specify Yes uerto Rican, et	or No-	14. Race - A	American Ind	ian,
9	after or Ite	by Funerai	1 Never Married 2 Ma	If Yes G	24 No		1 □ Yes 💥		мөхісап, Рі Specify:	ueno rican, et	C.)	Specify:	White, etc. White	2
8	urel',	d b	3 Widowed 4 □ Divorce	Year or	Dates:									
5	d within 72 hours after death with the Maryland Jiene. I then enturel; or terme 23a or 28a-f show The Madical Examinar must be notified at	Completed	(Specify only highe	nt's Education est grade completed)	16a. Dece	dent's Usual (kind of work of DO NOT use	Occupatio done duri retired)	on ing most of	working	16b	. Kind of Busine	ess/Industry	
12	withi iene. then	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		istrat					Federa1	Gove	rnment
b	e filed within al Hygiene. cother then vent, the Me	BeC	17. Father's Name (First, Middle					18		Name (First, N	fiddle, Maid	den Surname)		
/lar	should be nd Mental nmarked c	To E	Ira Walter H	?owe					Juli	ia Shan	k Row	re		
Maryland 21215-0036	2 shd and le m		19a. Informant's Name/Relation				_					ty or Town, Sta		
	1 and 1 Health em 27 ther tr		Craig M. Bor	nebrake	Jach	the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the section of the s			Ave. (Chamber Date	-	PA 172		
Baltimore,	0 ± 5		20a. Method of Disposition 1 Durial 2 Cremation	3 Removal from		Place of Disponentery, cres			l M			. Location - City		
틆	permit. Pa Depertmer Important eny Injury		4 □ Donation 5 □ Other (3		KC	se Hil						gerstow iery Fu		
Ba	Depermine Depermine Impo		Kaith	3,11	500									nd 21742
			23a. Part1. Enter the disease, shock, or heart failure. Lis	complications that	caused the dea								Appro	oximate val Between
	Physician		Immediate Cause (Final disease or condition	tonly one cause on									Onse	t and Death
	/Medical		resulting in death)	Due to	o (or as a conse	quence of):	nyelo	ma					1	yeur
	Examiner	Je .	Sequentially list conditions,	b										
	ed sit	ine	Sequentially list conditions, if any, I admit to in mindrate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a sonew	quanes of):								
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):					 		-	
760,	res that the death certificate be executed igned by the ettending physicien and be detached for use as the burial-transit	calE												
89	tificati g phy as the			0.										
ŏ	endin r use	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn birth 2 ☐ Fet		Ectopic preg	nancy				23d. Date of		
P.O. Box	e dea the ett	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☑ No		nant at time of		Other (spec					Month	Day	Year
<u>~</u>	d by fetach	Phy	9 ☐ Unknown Part II. Other significant conditi	One contribution to	death but not ra	rulting in the u	ndach ing on	en airen l	in Doet I	220	Did tobacc	o use contribut	a to the cour	to of doub?
ds,	The law requires that the death certifical tie has been signed by the ettending phy age 2 should be detached for use as the	d by	Turn. Other organicant conditi	one contributing to	dean but not re.	suiting at the d	nderlying cau	se givei i	iii Faiti,	256.	1 ☐ Yes	_		4 □Unknown
Sol	w require	iete								242	Was an	24h Wor	autonou lia	dinas available
Be	he lav e has	Completed								-	autopsy performed	? prior	to completion?	dings available on of cause of
ta		0	25. Was case referred to medica	ıl			_	26	6 Place of I	l 1□ ` Death (Check	Yes 2⊡*	No 1⊔'	Yes 2□N	0
<u>~</u>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1] Inpatient 2] ER/Outpatier	nt 3□ DOA					6 (36ther (5	Specify)	Ded Lyn
0	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	28c	Injury at Work?		28d. Des	cribe how in	njury occurred		
sio	tendi leath. for: A the fu	cati		igation not be			М	1 🗌 Yes	s 2 □ No					
	efter of All	Certification:	4 Homicide determ	nined 289. Place	e of Injury - At h ding, etc. (Speci	iome, farm, str fy)	eet, factory, o	office			tion (Street or Town, St	t and Number o tate)	r Rural Route	e Number,
_	Hospitel or 4 hours efte Funerel Dir tely filled in I		29a. Certifier 1 Certifyi	ng Physician: To th	e best of my kn	wledge, deatl	occurred at	the time.	date and pl	ace, and due t	o the cause	a(s) and manne	r as stated	
	To the Hospitel or Attending I within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examination	ation and/or in	vestigation, in	my opini	on, death o	ccurred at the	time, date	and place, and	due to the ca	ause(s)
	To the within 2 To the comple	W	29b. Signature and title of certifie	or a			29c. L	icense nu				Date signed (M		
1			Muihael		relove				1166			11/19	107	
21	1-9		30. Name and address of person	who completed cau	use of death (Ite	п 23а) (Туре,	Print)	,				11/19 Fegers	,	
יע שו	Sta	•	Michae () 31. Date filed (Month, Day, Year	MCOM.	Pagistrar's Sign	ature 4	100	Alle	el C	uno	, to	tejers,	tour	100
	Registr			0 2007	use of death (Item	D. 19	DENER							

			For State Registrar		State of	of Marylar		artment <i>rtificate</i>			and Me	-	giene Reg. No	000:	7 3931.
			1. Decedent's Na	ame (First, Mi	ddle, Last)							2. Date of De	ath		3. Time of Death
	Physic		Betty	Jean	Cooke							Month	Da		M
	/Medi Exami				tion, give street and nu	ımber)		4b. City, T	own, or	Location of		November		. County of Dea	11:43 a
	LAGIIII		199 Roll	ins Aver	nue, # 306			Rocky	ille				Mo	ntgomery	
	Funeral		5. Social Security		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			rthplace (State or Foreign country)
	Director	١.	578-40-5	009	1 □ M 2√□ F	77	Yrs.	IVIOITITIS	Days	nours		Dec. 15			nington, D.C.
	<u>و</u> _ و		Usual Residence			40.0									
	show show	_	10a. State	10b. Cou	1		ty, Town or Lo	ocation							10d. Inside City Limits
	Ba-f.s	cto	MD	Montg	gomery	Roc	kville								1x Yes 2 No
	or 24	Dire	10e. Street and I	Number				10f. Zip (Code				10g. Ci	tizen of What C	ountry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	199 Roll	ins Aver	nue, # 306			2085					U.S		
	r deg	ne	11. Marital Statu	S	Armed F		J.S. 13.	Was Decede If Yes, speci-	ent of Hi fy Cuba	spanic Ori n, Mexicai	igin? (Spec n, Puerto F	cify Yes or No Rican, etc.))-	 Race - Am Black, Whi 	
98	or it	Ę.		arried 2□ N	lamed 1 ☐ Yes If Yes, G	2√ No ive No		1 ☐ Yes 2		Specify:				Specify:	
21215-0036	ural"; i Exa	d by	3 ∐Widowe	d 4 ☐ Divord	year or L	Dates:	7							Wh	ite
5	"nati	Completed	(S)	15. Dece c pecify only hig	dent's Education phest grade completed))	(Give	dent's Usual kind of work DO NOT use	cdone o	lurina mos	t of workin	g	16b. K 	(ind of Business	s/Industry
2	vithin ane. .han	E D	Elementary/Se	econdary (0-12	2) College	(1-4or 5+)				,			D		C 41 N
	Hygie Hygie her t	ပိ	17. Father's Nan	no / Eiret Midd	flo Last)		CIVII	Servant	Т	18 Mothe	ar'e Namo	(First, Middle			f the Navy
anc.	be find Hold Hold Hold Hold Hold Hold Hold Hol	Be		`	iie, Lasij								, maidei	i Quiname)	
ž	narke	ျင	George				401-14-111		(041		Musgr			- a	7/ 0 / 1
Maryland	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical				onship (Type. Print)									or Town, State,	Zip Code)
	Health tem 27 i		D.L. Bur		iew	20h						er Sprin		D 20906 ocation - City o	r Town State
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tronce.				on 3 Removal from	State	Place of Dispo cemetery, cre	matory or oth	her plac	e)		ate	200. L	ocation - City o	1 Town, State
ţ	tmer tant: lury			n 5 Other		Ft.	Lincoln					6, 2007		ntwood, N	
3al	permit. F Departme Importan any injur		21. Signature of	Fuperal Serv	ice Ligensoe	η.	11/2	2. Name and	Addres	s of Facili	^{ty} Hines	-Rinald:	i Fun	eral Home	e, Inc.
	O		TA	your	t Will	eme								ng, MD 20	
			23a. Part1. Ente shock, or h	er the disease near failure. I	, or complications that List only one cause on	caused the dea each line.	th. Do not en	ter the mode	of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
100	Physician		Immediate Caus disease or cond	lition	_ Athero	sclerotio	c Cardio	vascula	r Dis	sease					20 years
	/Medical		resulting in deat	th)	Due to	(or as a consec	quence of):								
53	Examiner		Sequentially list	conditions		es Melli									20 years
	₽ .=	Examiner	Sequentially list cause. Enter Ur Cause (Disease	nderlying	Due to	(or as a consid	cuence offs								
	acute nd trans	am	Cause (Disease that initiated ever resulting in deat	rits	Ü	ension									20 years
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ě	resulting in deal	II) Last	Due to	(or as a consec	quence of):								
376	ate b	dical			d										
9	death certifica attending ph I for use as th	Med	IF FEMALE:									5.50			
Вох	ith ce tendi or use	Physician/Med	23b. Was deced			utcome pf pregn birth 2 ☐ Fet		⊒Ectopic pre	gnancy				1	23d. Date of de	
	e dea he at ed fo	sici	1 ☐ Yes			nant at time of		Other (spe						Month	Day Year
P.0	at the	h	9 □ Unkno												
	ires that the de signed by the a be detached t				ditions contributing to	death but not res	sulting in the u	ınderlying ca	use give	en in Part I		23e. Did	tobacco	use contribute	to the cause of death?
ğ	w requir been si should I	Completed by	Alzheimen	r's Dise	ase							1 🗆	Yes 2	P. S. No 3 ∏ F	Probably 4 ☐Unknown
ည္ပ	e law r has be je 2 sh	plet										24a. Was		24b. Were a	autopsy findings available completion of cause of
ď	The lite has bage	Eo										auto perfe 1□ Yes	ormed? 2 □ N	death?	, ,
ta	ician: Th certificate ector, pag	Be C	25. Was case re	eferred to med	lical					26. Place	e of Death	(Check only		0 1 1010	3 2 110
>	Attending Physician: r death. ector: After this certification of the funeral director, in	To B	examiner? 1 ☐ Yes 2	No No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	Othe	or.				6 ☐Other (Sp	ecify)
ō	g Ph er thi eral	Ξ̈́	27. Manner of D		28a. Date	e of Injury nth, Day Year)	28b. Time o	of 28	lc. Injun Worl			8d. Describe			
0	nding f th. r: After e funera	ţ	1 K Natural 2 ☐ Acciden	5 □Per inve	estigation	illi, Day rear)	Injury	М		vr Yes 2 🗌	No				
Division or Vital Records,	Attendir death.	Certification:	3 ☐ Suicide 4 ☐ Homicid	6 □ Cou	uld not be ermined 28e. Plac	e of injury - At h	ome, farm, st	reet, factory,	office		2				Rural Route Number,
Ö	al or afte i Dir d in	ert	4 [] 1 101111010	16	Dunc	ding, etc. (Spec	ny)					City or To	wii, Stat	e)	
	ospital or A hours after uneral Dire ly filled in by		29a. Certifier		fying Physician: To th										
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one)	2∐ Medí	cal Examiner: On the and ma	basis of examin nner stated.	ation and/or i	nvestigation,	ın my o	pinion, dea	ath occurre	ed at the time	, date ar	nd place, and du	ue to the cause(s)
	To the H within 24 To the Fu	Me	29b. Signature a	and title of cer	tifier	01-				number	٤			ate signed (Mor	
1			> /	Pri	olyn DI	Kani	VMI	ol	030	1381	0		1	11/14/	07
- (2		30. Name and a	ddress of pers	son who completed cau	use of death (Ite	m 23a) (Type							-	
			1	-	r, M.D., 9715				e.#50	01, Ro	ckvill	e, MD 20	0850		
	St	ate	31. Date filed (N	Nonth, Day, Ye	ear) 32.	egistrar's Sign	ature	9 E							
	Regist	rar	1	NUV 1	5 2007		K A	mark 1							

			For State	State o	of Maryla	•	artment of H		lental Hygie	ene	07	2.0	212
			Registrar 1. Decedent's Name (First, Middle	e. Last)		Cei	tificate of l	Jeath	Reg 2. Date of Death	. No U	UI	3 8 3. Time o	
	Physicia /Medic		Richard	D.		Dicken		Sr.	Nov 24	, ^{Day} 2007	Year	7:20p	om ™
	Examin		4a. Facility Name (If not institution		ımber)			Location of Death		4c. County			
	Funeral	<i>i</i>	11303 Ore Str 5. Social Security Number	eet 6. Sex	7. Age (in yi	rs. last birthday)	Cumbe	If Under 24 Hrs.	8. Date of Birth	Alleg	9. Birthpl	ace (State	or Foreign
	Director		142-28-6991	1 M 2 □ F	73	Yrs.	Months Days	Hours Min.	Apr 18,	1934	Coum	MD	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation				10	d. Inside C	ity Limits
;	e Mary ta-f sh	ctor	MD All	egany		Cur	nberland					1 XYes	2 No
1	with th	Director	10e. Street and Number				10f. Zip Code	21502	100	J. Citizen of W	Vhat Coun JSA	try?	
	ms 23	Funeral	11303 Ore Str	12. Was Dec	pedent Ever in	U.S. 13.	Was Decedent of H f Yes, specify Cuba		ecify Yes or No-	14. Race	e - America		
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural;" or Items 23a or 28a-f show is marked other than "natural;" or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Fui	1 Never Married 2 Marr	I It Yes. Gi	2 ☐XNo ive		r Yes, specify Cuba 1 □ Yes 2 □ MTo	Specify:	Hican, etc.)	Specify	k, White,		
200	hours aturai" cal Exa		3 ☐ Widowed 4 ☐ Divorced 15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Bu	WI		
2 2	ithin 72 ne. nan "na Medi	Completed	(Specify only higher Elementary/Secondary (0-12)) (1-4or 5+)		kind of work done o		I .	.			
7	filed w Hygier ther th		12 17. Father's Name (<i>First, Middle,</i>	Last)		sanıt	ation truck		e (First, Middle, Ma	Sanitat		ompa	iny
0	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	Merrill Issac	*				Lavina	Kathryn	Winters	s Dick	ken	
Val.	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. And Health and Mental Hygiene. The Mealth and Mental Hygiene. The Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations Vernadine Did		wife		ng Address (Street &			City or Town, perland		Code) D 21	502
ָ ט	f Healt f Healt ftem 2		20a. Method of Disposition		20b		sition (Name of matory or other place			c. Location -			
	Page tment o tant: If jury or		1 ☐ Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)		unset Mei	morial Park	3 5 f	11/28/2007	Cumb	erlan	d	MD
מ	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other trai		21. Signature of Funeral Service	Licensee		1 22	2. Name and Addres Scarpe 108 Vir	ss of Facility Illi Funeral Ho ginia Avenue		d. MD 21	502		
	1 1 N		23a. Pall Enter the disease, or high, or heart failure. List	comp ations that only ne cause on	caused the de	eath. Do not ent						Approxima Interval Be	tween
F	Physician (Madical		Imme / te Cause (Final disea, e or condition resulting in death)	La. CF	Heir	pann	of L	25			- 1	Onset and	Death
١	/Medical Examiner		,		(or as a cons	equence of):							
	±	iner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a cons	equence of):							
32.	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a cons	equence of):							
,00,	ate be executed hysician and the burial-transit	dica! E		d									
00 4	ertifica ling ph e as th	Med	IF FEMALE:	00-16						I			
YOU !	death o	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live 4□Preg	utcome pf pre∈ birth 2 □ F gnant at time c	etal death 3	Ectopic pregnancy Other (specify)	/			te of delive inth	ry Day	Year
	at the c by the	hysi	9 ☐ Unknown	9□Unkr									
ָה מי	ires th signed	by	Part II. Other significant condition	ons contributing to c	death but not r	resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	icco use conti : 2 ☐ No		e cause of	
colds,	s been should	Completed	ATPIAI 2	- 3021/	AD CA	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	71 70		24a. Was an	24b. \	Were auto	psy findings	available
ב ו	The la ate has page 2	Som C		10000	,,,,,,				autopsy perform 1∐ Yes 2	ed? i	prior to cor death? 1 ∐Yes	npletion of 2∐ No	cause of
N II I	iclan: certific ector,	Be	25. Was case referred to medica examiner?	Hospital:			oth Oth	or.	h (Check only one				
5	Phys er this eral dir	1: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o	II 3 DOA	4 Li Nursing Ho	ome 5 Resider 28d. Describe hov		_ ` ' '	/)	
2	ending afh. or: Afte he fune	ation	1.X Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	nth, Day Year) Injury		Yes 2 □ No					
	or Att after de Directa In by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained Zoe, Flac	ce of injury - Arding, etc. (Spe	t home, farm, str ecify)	reet, factory, office		28f. Location (Stre City or Town,		er or Rura	l Route Nu	mber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral inferctor. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C		ng Physician: To th Examiner: On the land man									(s)
,	To the within To the comple	Med	29b. Signature and title of Certifie		20		29c. Licens		29	d. Date signe	d (Month,	Day, Year)	
•				03627	LON	=	123	31875	1	2000	MBO	2 2	6,200
	3		30. Name and address of person	wno completed Tu	use of death (I	tem 23a) (Type,	SETON 1	51875 DR. CW	WBBRU	two, r	no.	RISC	2
	Sta		31. Date filed (Month, Day, Year)	2007	Registrar's Si	nnature /	andi)			•			
	Registr	ar	MUND	1 4001	M. M. St. Comment	State of the state							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Sue Martha Edmonds November 10 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner General Hospital ambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🗷 F Min Hours Country 220-52-872 Maryland Director Oct. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Injury or other traumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director Dorchester ambridge Items 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 625 12. Was Decedent Ever in U.S. Armed Forces? 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Hygiene. 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) /2College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other thin any Injury or other them. 001 Kestaurant Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keene ပ Kate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pordova Road-Cordova, Mary land 216 25

Vame of Date 20c. Location - City or Town, State Ida Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State Thomastown Cenetery 11/24/07 Hillsboro, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

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21. Signature of Funeral Individual Service Licensee

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29. Name a MD. 2/6/3 ambridg Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUD /Medical Due to (or as a consequence of): Examiner HYPURTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by POLYCESTIC KLONEY DISEASE 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an autopsy certificate 2 Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation (Month, Day Year) Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

29b. Signature and the of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00065107

29d. Date signed (Month, Day, Year)

2007

MD

ADAM GARRETSON MD 503A MUIR ST CAMBRIDGE, MD 21613

State Registrar

31. Date filed (Month, Day, Year)

32. Reistrar's Signature

NOV 15

within 24 hours after death.

To the Funeral Director:

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

November 21, 2007

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

		1	For State Registrar	State o	f Maryland	-	rtment of H tificate of L			iene 9. No. 2 (07	38346
П		-	1. Decedent's Name (First, Mide	lle, Last)			-		2. Date of Death	h Day	Year	3. Time of Death
	Physicia			Montell	Sherma	n Fletc	her		1	11, 2007	Tour	0530 ^M
	/Medic Examin		4a. Facility Name (If not instituti	on, give street and nu	mber)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Calver	t Memorial Hos	pital		Pr	ince Frederic	ck		Calv	ert
-	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Count	ace (State or Foreign
	Director		217-14-7605	1 ∑ M 2□F	91	Yrs.	Working Dayo	Tiodio IIIIII	Dec 28,		_	/laryland
	D		Usual Residence of Decedent		I too City	. Town orlo	nation				10	Od. Inside City Limits
	rylar show	. 1	10a. State 10b. Coun		TOG. City	, Town or Lo						1 ☐ Yes 2 ☑ No
	e Ma ga-f s	용	MD	Calvert				Huntingtown				
	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than medical Examiner must be notified at ant, the Medical Examiner must be notified at	<u>a</u>	2051 Hatfield Road					20639		14 Bac	U.S.A.	
	r dez	Funeral	11. Marital Status	Armed Fo	edent Ever in U.s prces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S) in, Mexican, Puert	necity Yes or No- no Rican, etc.)		k, White,	
g	or i	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	l It Yes, G	2 No ive		1 ☐ Yes 2 ◯X No	Specify:		Specify	/: Black	(
9500-61212	ural'			ent's Education	Jales.	16a Decer	dent's Usual Occup	ation		16b. Kind of Bu		
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N	filed Hygir ther int, ti	ပ္သ	17. Father's Name (First, Middl	e, Last)				18. Mother's Nan	ne (First, Middle, I	Maiden Surnan	ne)	
ä	8 1 a e	Be	,	Asbury	Eletcher				Ber	tha Johns	on	
Maryland	should be filed within 72 hours after death with the Marylan and Mertle Hygiene. In Mertle Hygiene. In arrived other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ို	19a. Informant's Name/Relatio		T TOTOTION	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number	; City or Town,	State, Zip	Code)
<u>≅</u>	d2s than 7 is trau		Dawn Myles /Gra	* * * * * * * * * * * * * * * * * * * *		2007	Hatfield Roa	d Huntingtov	vn, MD 2063	9		
	es 1 and 2 should bot Health and Ment Item 27 is marked rother traumatic	-	20a, Method of Disposition	daudgc.	20b. P		sition (Name of matory or other place			20c. Location -	City or To	wn, State
و			1 XBurial 2 ☐ Cremation		State	-		1 44	/17/07	Г	Dunkirk.	MD
Baltimore,	permit. Pag Department Important: I any injury c		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Servie				Memorial Garde Name and Addre		717707		Julikii K.	, IVID
Ва	permit. Pag Department Important: I any injury o		h	. Sewell	2		Sewell F	uneral Home			45.000	70
	CONTRACTOR OF STREET				caused the death	h Do not ent			oad Prince E		VID 206	Approximate
			23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final	ist only one cause on	each line.	1.	,	V				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Veni	//-)						
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit											
87	phys the	dical		d								
×	death certific attending p	Physician/Me	IF FEMALE:	23c. If yes, o	utcome pf pregna	ancy				23d. Da	ate of delive	erv
Vital Records, P.O. Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 Feta	Ideath 3	□Ectopic pregnanc □ Other (specify) _	у			onth	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk							_	
۵.	w requires that the di been signed by the should be detached	문	Part II. Other significant cond	itions contributing to	death but not res	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to th	he cause of death?
g S	signe signe	l by	(e(Pb-1	Vascale	1 ACC	idon	+		1 🗆 Y	es 2 No	3 Prob	oably 4 Unknown
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7	ohys this c	မ	1 Yes 2 No		Inpatient 2 e of Injury	28b. Time	nt 3 DOA	4 ☐ Nursing I	lome 5 ☐ Resid			fy)
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Sic	tend leath tor: the f	cati	Z MCCIGETT	stigation	co of injuny - At h	ome farm st	reet, factory, office	1100 2	28f. Location (S	Street and Num	ber or Rura	al Route Number,
Division or	or At	Certification:	4 ☐ Homicide dete	ermined buil	ding, etc. (Speci	fy)	ioot, taotory, omeo		City or Tow	n, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1-Certifi	ying Physician: To t	he hest of my kno	owledge dea	th occurred at the t	ime, date and place	e, and due to the	cause(s) and m	nanner as s	stated.
	Hos 24 hc Fun	Medical	(Check only 2 Medione)	cal Examiner: On the	basis of examina	ation and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place	, and due t	to the cause(s)
	ithin ;	Mec	29b. Signature and title of cert				29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
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()14 [^]	4		30. Name and address of pers	Ma thur	M.D	ıı ∠əa) (Type	, • 1014)	Prince 8	rederict	& MI	206	78
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Morton Farber November 12, 2007 2:02 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months 91 Director 241-30-5860 Sept. 21,1916 N. Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Gaithersburg 1X Yes 2 No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 115 Leekes Lot Way U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No Army If Yes, Give Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department Store Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mollie Farber Henry Farber P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Leekes Lot Way, Gaithersburg, Maryland 20878 19a. Informant's Name/Relationship (Type. Print) Maralyn Farber - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 11/15/2007 Clarksburg, Maryland 21. Signature of Funeral Service License ²² Name and Address of Facility Edward Sagel Funeral Direction, Inc. Donald (1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque no Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown the funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? rlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No 1☐ Yes or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 X Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director:

> State Registrar

29b. Signature and the of certifier

MASREEN

NOV

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 5 2007

32 Posistrar's Signature

DHMH 17 Rev 1/2001

29c. License gumber

7619 Carroll Avenue, # 205, Takoma Park, Marylahd 20912

29d. Date signed (Month, Day, Year)

6

State 31. Date filed (Month, Day, Year)

Registrar NOV 3 0 2007

101 COLONIAL Way

32. registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sun, mo

Neil E. Lattin, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 8, 2007 **Physician** John Hampton Gulledge 10:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4102 Overlook Court Calvert Dunkirk If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**反**M 2□F 68 Director 579-50-9942 Apr 2, 1939 Wash. D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Calvert. Dunkirk Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4102 Overlook Court 20754 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗵 No Specify: ģ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operating Engineer Local 77 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gulledge Wade Hampton Dorothy Willoughby ٩ 19a. Informant's Name/Relationship (Type. Print) (Significant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Hutchinson Other) 4102 0.02

20b. Place of Disposition (Name of cemetery, crematory or other place) 4102 Overlook Ct Dunkirk, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State Nov 9, 2007 Lee Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Michael W 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the buriar-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypothyroidisin 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 🗆 No Degenerative Joint disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cedifier 29c. License number D50653 11-9-2007

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gyan Surana, MD 5851 Deale Churchton Road Deale, MD 20751

31. Date filed (Month, Day, Year)

32. Registra Signature NOV 1 4 2007

ALbert W. Golem Des Ki Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

•		Please	Type or Prin	t in B	lack In	delible Ink.	Ensure A	II Copies	Are Legible	e.
		For	State of Ma	ryland				<i>l</i> lental Hyg	iene	
Amende	d	State Registrar 10d, FH, T(7 pha	Cei	rtificate of	Death		eg. No. 20	<u> </u>
Physicia /Medic		1. Decedent's Name (First, Middle, La Albert W. Gole	*					2. Date of Dear Month November	Day Ye	3. Time of Death 67 1619 M
Examin		4a. Facility Name (If not institution, give	,	- 4		-	Location of Death		4c. County of I	
-	** **		PITAL (a) C	AST a	St birthday)	LAS If Under 1 Year	TON If Under 24 Hrs.	8. Date of Birth	Talb	Birthplace (State or Foreign
Funeral Director			X □M 2□F	81	Yrs.	Months Days	Hours Min.	(Month, Day)	Year)	ilford CT.
iryland ihow i at		10a. State 10b. County			Town or Lo					10d. Inside City Limits
he Ma 8a-f s	Director	Md Talbot		St.	Mic.	haels			0- 000	X-1 XYes 2 No
with t		10e. Street and Number 102 West Chew A	Ave			10f. Zip Code 21 663		1	0g. Citizen of Wha	: Country?
death ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - /	American Indian,
rs after I', or ite xamine	by Fu	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 □ N If Yes, Give Year or Dates:	。 WWII		1 □ Yes 2 🟋No	Specify:	nican, etc.)		White, etc. White
72 hou "natura dical E	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occup	durina most of work		16b. Kind of Busin	ess/Industry
within ene. than he Me	ldwc	Elementary/Secondary (0-12) 12 years	College (1-4or 5-	+)		nt Supe:	,		Bridgep	ort Brass
be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Las Walter A. Gole	t)						Maiden Surname) nska	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	ို	19a. Informant's Name/Relationship Helen Golembe		,	19b. Mailir	ng Address (Street				nte, Zip Code) , Md. 21663
1 and 2 Health a em 27 is		Helen Golembe	skı (Wile			west Cne			20c. Location - Cit	
Pages nent of I ant: If ite ary or o		1 ☐ Burial 2 【Cremation 3 [4 ☐ Donation 5 ☐ Other (Special		ce	metery, crei	cremate Cremate	ce) ¦			
permit. Departm Importa any inju		21. Signature of Funeral Service Lice	nsee		R R	Name and Addre	ss of Facility	ey Fune	ral Hom	e,PC
		23a. Part1. Enter the disease, or con	nplications hat caused	the death.	. Do not ent	O BOX er the mode of dyir	518 S1	or respiratory arr	aels, M est,	Id . 21663 Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition			lar	Fibrilla	tion			Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	SAGA	ence of):	Hem	Nisea	se		10 7 car
sit sit	iner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequ	erra of):	htery	000			10 year
be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	onsequ	ence of):	H ESI E	one.			- July
cate be physicia the bur	dical		d							
death certificate b attending physic	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnar	ncy	7e			23d. Date o	of delivery
he death the atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□Unknown]Ectopic pregnancy]Other <i>(specify)</i> _	<i>y</i>		Month	Day Year
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	by	Part II. Other significant conditions	contributing to death bu	not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	_	ute to the cause of death? ☐ Probably 4 ☐ Unknown
v requ	eted	7)(1.00(24a. Was a		re autopsy findings available
The lav	Completed							autop	sy prio med? dea	or to completion of cause of
sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?	Hamitali			011	26. Place of Dea			
ding Physi h. After this c funeral dire	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur		R/Outpatier 28b. Time o	nt 3□ DOA Oth f 28c. Injur	4 LINUTSING H		ence 6 Other owninjury occurred	(Specify)
nding ath. r: After e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Injury	Wor	k? Yes 2∐No		on injury occurred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		ry - At hor c. (Specify	me, farm, str	eet, factory, office	-	28f. Location (S City or Tow		or Rural Route Number,
ospital hours a uneral ly filled		29a. Certifier 1 Decertifying P	hysiclan: To the best on the basis of	of my knov	vledge, deat	h occurred at the ti	me, date and place	, and due to the o	cause(s) and mann	er as stated.
To the Hos within 24 hd To the Fun completely	Medical	one)	and manner sta	ted.		29c. Licens			29d. Date signed (/	
N With		Nasell C	L. Schil	un	80	HO	12587		11-13-	
15		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,	Print)	Easton	mb 2	1601	
Sta Registr		31. Date filed (Month, Day, Year)	OO Delininkun	wa Cinnak	re		•			
		1004 - 0	1	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** JAMES GRAY 11 2007 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 210 North Division St. Unit 5 Ocean City Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F 269-60-9879 50 5/11/1957 Director OH Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f sh notified 1 XYes 2 No Director Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 21842 USA 210 North Division St. Unit 5 Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ 3 Widowed 4 Noivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pawn Shop Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Travis Gray Sarah Louise Keeley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8159 Midhaven Rd., Baltimore, MD 21222 Janice Gray / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the Important: If Ite any Injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park | 11/17/2007 | Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service 108 William St., Berlin, MD 21811 23a. Par J. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) HOUTE MYOCARDIAL MMEDIATE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was ar autopsy performed 2 200 1☐ Yes Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica ttely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

BA 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

NOV 15

ZWORTH /ND 32. Registrar's Signature

IND

006241

11-12-07

SNOW ST. SNOW HILL MD, 21863

		For State Registrar	State of	Maryland		artment of H		nd Mental Hy	giene	2007	38352		
* Phys		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 12 2007 2											
	dical niner	4a. Facility Name (If not institution Hebrew Home o	n, give street and num		ton	4b. City, Town, or				County of Death Montgome	3:00 A. M		
Funer Directo		5. Social Security Number 295–34–4199		7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	ıy, Year)	9. Birthplace (State or Foreign			
e Maryland Se-I show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prin	10d. Inside City Limits 1 🖔 Yes 2 □ No										
th with th	Funeral Director	10e. Street and Number 4307 Skipton C	ourt		10g. Citizen of What Country? U. S. A.								
Destriction of the property of	d by Fune	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed For	2 □No Arm	У	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1 No	spanic Origin, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	(Specify Yes or No- erio Rican, etc.) 14. Race - Ame Black, Whit				
d within 72 hadjene.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1- 4 Ye	4or 5+) ars	(Give life. i	dent's Usual Occupa kind of work done o DO NOT use retired, al Clerk	furing most o	of working		S. Gover	usiness/Industry Government		
should be file and Mental Hy marked other analic event.	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First Monitor (Line)											
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relations Mabel Guttma			4307	Skipton	Court,	or Rural Route Numb. Upper Mai	er, City o	y or Town, State, Zip Code) oro, Maryland 20772			
diffiliorers rmit. Pages 1 partment of H portant: If Iter y injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		tate cer	ed Sh	sition (Name of natory or other place e1 Emmes	11	Date L/15/2007	Cap	itol Heig			
permit. Departinimporta	SUC SUC SUC SUC SUC SUC SUC SUC SUC SUC	21. Signature of Funeral Service	State	myer		091 Rocky	ille F	neral Dire	<u>vi11</u>	n, Inc. e, Maryla	and 20852		
or the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit management.	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, learning 1. minimal data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
wrequires that the death certific been signed by the attending p should be detached for use as:	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day Year		
quires that an signed b	by P	Part II. Other significant condition Hypercal		to use contribute to the cause of death?									
The law reicate has been rapid to page 2 sho	Completed	Renal Sailure 24a. Was an autopsy performe 1 Yes 25									osy findings available apletion of cause of		
tending Physician: The lav Beath. tor: After this certificate has the funeral director, page 2	ation: To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi	Hospital: 1 In		P/Outpatien 8b. Time of Injury	t 3 DOA Othe	28d. Describe I	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		e, farm, stre	eet, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical one)	ng Physician: To the base Examiner: On the base and manner	sis of examinatio	edge, death n and/or inv	restigation, in my op	inion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as sta diplace, and due to	ited. the cause(s)		
3	Σ	29b. Signature and title of certifie	1. Bense	n MI		29c. License number 29d. Date signed (Mor					ith, Day, Year)		
		30. Name and address of person 6/2/ Mo	ntrose 1	of death (Item 2	Rock	Print) Dr.	Linda 1D	A. Benson 20852					
S Regis	State strar	31. Date filed (Month, Day, Year)	2007	gistrar's Signatu	ге	rede s							

07-08784 Ruth Greenspan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 State of Maryland / Department of Health and Mental Hygiene

th Greenspan		St 1- For State Amend Ite Registrar	ate of Marylands Toa-f pe	and / Depa r inf.,	rtment of	Health Beath	and	Menta	ΙНу	giene	Reg. No.	20	007	3835
Physicia edical Exami	an/	Decedent's Name (First, Midd								Date of De Month Novembe	eath	Year		e of Death 19 hrs
Julijui		Ruthanne Green 4a. Facility Name (if not institution Suburban Hospital	L.	umber)	4	b. City, Tov Bethese		ocation of [Novemb	4c.	County of I		
Funeral Director		5. Social Security Number 578-62-5542	6. Sex	7. Age (In yrs. Ia	ast birthday) 85 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24Hrs. Min.	8. Date of E	,	F	9. Birthplace Foreign Country)	
Aaryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State 10b. County Palm B Mentge	each		Town or Location					Nov. os			10d. lr	riside City Limits Yes 2 No
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tent 27 is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Medical Examiner must be notified at once.	eral Director	10e. Street and Number 500 South Ocean B 5600 Wissensin Ave 11. Marital Status	12. Was De	cedent Ever in U.			of Hispa			cify Yes or N	USA		American Ind	ian, Black,
ours after death atural", or iter	d by Funeral	1 Never Married 2 X M 3 Widowed 4 Div 15. Decedent's Education (Spe	1 16a. Deceden	Yes 2 No specify: Specify: Specify: Specify:						Specify:	White usiness/Industry			
5-0036 ed within 72 ho tygiene. other than "ns the Medical Ex	ompleted	Elementary/Secondary (0-12)	2	1-4 or 5+)	Mana	st of workinger						tal Of	fice	
21215-0036 Juld be filed within 72 hours afte Mental Hygiene marked other than "natural"; cevent, the Medical Examiner	To Be Co	17. Father's Name (First, Middle Alexander A. Steil 19a. Informant's Name/Relations	19b. Mailing	Address		Sadye	Silb	First, Middle ersteir eral Route N	n		. State. Zip Co	ode)		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingry or other traumantic event, the Med	F	Sidney Greenspan/ Spouse 5600 Wisconsin Ave.#602, Chevy Chase, MD 208									20815			
Baltimore, permit. Pages I a: Department of He Important: If ite Injury or other to		4 Donation 5 Other Specify: Washington Hebrew Cemetery Nov.16, 2007 Washington 21 Signaluse of Funeral Service Licensee 222 Name and Address of Facility Hines-Rinaldi Funeral Ho 11800 New Hampshire Ave., Silver Spring, MD										ome, Inc	· .	
Physician /Medical xaminer pur us pur l Examiner	23a. Part I. Enter the disease, o failure! List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	a. Intracereb Due to (or as b. Due to (or as c.	ral Hemorrha a consequence of a consequence of a consequence of	ge f):	ne mode of	dying, s	uch as car	diac or	respiratory a	arrest, sho	ock, or hear	t Appi Beh	roximate Interval ween Onset and Death	
- 8 .p.E	Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in topast 12 months? 1 Yes 2 No 9 Ur	he 1 Live	, outcome of preg birth gnant at time of de nown	2 Fe	tal death her (Specif	3 [jy)	Ectopic p	oregnan	су	230	d. Date of d Month	delivery Day	Year
P.O. es that the igned by be detach	Completed by Ph	Part II. Other significant condi Myelodysplastic syn		to death but not re	esulting in the c	inderlying c	ause gi	ven in Part	· I.	1 24a. Wa au pe	Yes 2 as an topsy	No 3	ere autopsy from to complete	use of death? 4 Unknown findings available tion of cause of
on of Vital Records, nding Physician: The law requir th.	To Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Per	ER/Outpatient							ence 6	6 Other:			
Division Hospital or Attendir 24 hours after death. Funeral Director: A	Certification:	2 Accident Inve 3 Suicide 6 Cou 4 Homicide	estigation 28e. Pla 28e. Pla 28e. Pla 28e. Pla 28e. Pla 28e. Pla 28e. Pla	<u></u>						or Town	n, State)			ute Number, City
To the Hospital Within 24 hours a To the Funeral I completely filled	Medical	ICheck only	aminer:On the basis and manner	of examination a	ige, death occur and/or investiga	curred at the time, date and place, and due to the caugation, in my opinion, death occurred at the time, date 29c. License number O.C.M.E.					ause(s) and manner as stated. ate and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) November 13, 2007			
		30. Name and address of perso Carol Allan, MD As	sistant Medica	Examiner	111 Penn	Street, B	altimo	ore, MD	21201				· · · · · · · · · · · · · · · · · · ·	
Si Regis	tate	31. Date filed (Menty, Pay Year	2007 32	egistrar's Signat	ure de	AF D								

		1- State of Maryland		rtment of H		-	giene Reg. No. 🤈 (דחר	30351		
Physici /Medic		Decedent's Name (First, Middle, Last) DORIS LORRAINE HUFFMAN				2. Date of De Month	Day	Year 2007	3. Time of Death 2016 P M		
Examir Funeral		4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	4b. City, Town, or ANNAPOLI If Under 1 Year	S If Under 24 Hrs	8. Date of Bir	ANNE	4c. County of Death ANNE ARUNDEL			
Director	_	579-22-1722 1 □ M 2 X F 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	9. Birthplace (State or Foreign Country) MINNESOTA 10d. Inside City Limits			
th with the Ma 23a or 28a-f s ist be notified	al Director	MARYLAND QUEEN ANNE'S STEV 10e. Street and Number 108 MONROE MANOR ROAD	VENSV)	11LE 10f. Zip Code 21666				1 ☐ Yes 2 🕱 No g. Citizen of What Country? NITED STATES			
ite, with yiell of ILI INCOME. If and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:	l It	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (S	pecify Yes or No)- 14. Ra Bla	ack, White, e	an Indian, etc.		
filed within 72 h Hygiene. other than "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	ent's Usual Occupa kind of work done of OO NOT use retired	furing most of wo.)		AIRCRAFT				
an ynanu 2 should be file 1 and Mental H) 1s marked oth 1s umatic event	To Be	17. Father's Name (First, Middle, Last) HAROLD HERMANSON 19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	CHRISTI	NE LARSO	(First, Middle, Maiden Surname) LARSON Route Number, City or Town, State, Zip Code)				
Page lent o nt: If		20a. Method of Disposition 20b. Place cem 1	e of Dispos etery, crem	IARGARET I sition (Name of natory or other plac LLE CEMET	e) NOVE	MBER 15	20c. Location	- City or Tov	wn, State		
permit. Departm Importa any Inju		21. Signature of Funeral Dervice Licensee	FE 10	Name and Addrese LLOWS, H	s of Facility ELFENBEI K ROAD,	N AND NE	WNAM FU	JNERAL	, MARYLAND HOME, P.A. 1619		
Physician /Medical Examiner	ər	Due to (or as a consequent Sequentially list conditions.	uE nce of):	C)+/LWV (,		Approximate Interval Between Onset and Death		
cate be executed physician and the bunal-transit	dical Examiner	tany, leading to intraclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C									
The law requires that the death certificate are has t een signed by the attending physicage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year				
requires that een signed hould be det	by	Part II. Other significant conditions contributing to death but not resulting to LEUCI	111		en in Part I.	23e. Did t	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
	se Completed	25. Was case referred to medical	LUR		26. Place of Dea	psy prmed? 2 No					
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral direct. r, page 2 to	Certification: To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (standard in the content of the content									
he Hospital n 24 hours a he Funeral I pletely filled	ledical Ce	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)									
Tot H Tot Tot Tot Tot H	Me	29b. Signature and title of certifier Description Land Compared Course of death (Item 23)	3a) (Tvne I		1437		29d. Date sign	ed (Month, E	oay, Year)		
Sta Registi		Darcey Ibitoye 2001 Medic 31. Date filed (Month, Day, Year) 32. July Strar's Signature NOV 14 2007	5/2	ackness	1. Anno	ipolis,	nd s	1401			

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

	Plea	se Type o								•	e.	
For State Registrar		State	of Mary	and / Dep <i>Ce</i>	artment o <i>rtificate d</i>			-	giene Reg. No.		07 (20255
1. Decedent's Name	e (First, Middle	e, Last)						2. Date of De Month	ath Day	~ U	3. T	imedi Beath
Harvey Wa								NOV.	14	, 200	57 9	:58 AM
4a. Facility Name (I	-		4	2.1	4b. City, Tow	15 1			4c.	County of	Death Com	100
5. Social Security N		ab & Nu		yrs. last birthday,	If Under 1 Y	74.0	er 24 Hrd.	8. Date of Bir	th			State or Foreign
220-28-05		1 X M 2 □ F	75	Yrs.		ys Hours		10/21/	1 932	"	Country)	MD
Usual Residence of								10/21/	1302			
10a. State	10b. County		100	. City, Town or Lo	ocation							side City Limits
MD	Wic	omico		Salisbur	у						1 [Tyes 2⊠No
10e. Street and Nu					10f. Zip Coo						at Country?	
1008 Cara	avan Wa	<u> </u>	1.75		218		011010		USA		A	
11. Marital Status 1 X Never Marr	ind OD Mon	Armed	Forces?	in U.S. 13.	If Yes, specify	of Hispanic (Cuban, Mexic	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.))-		American Ind White, etc.	ian,
3 ☐ Widowed		If Yes, Year or			1⊡Yes 2X		fy:			Specify:	White	
(Ѕрес	15. Deceden cify only highe.	t's Education st grade complete	d)	16a. Dece	dent's Usual Od kind of work do DO NOT use re	ocupation one during m	ost of work	ing	16b. Ki 	nd of Busir	ness/Industry	
Elementary/Seco	ondary (0-12)	College	(1-4or 5+)		eral Dir				Fu	neral	Home	
17. Father's Name		•						e (First, Middle		.,		
Fred Warr				1				lizabet				
19a. Informant's Na								ral Route Numb)
G. Michae		еу /	20	b. Place of Disp				isbury, _{Date}			ty or Town, Si	
	Cremation	3 □Removal fro pecify)	m State	ape Henl	matory or other	place)					d, DE	late
21. Signature i Fu	eral Service	Licensee	•	2				e Burba Berlin,			1 Home	
23a. Part1. En r t	h disease or	complication that	t caused the	leath Do not en						21011	Appr	oximate
shock, or hea	ırt lailure. List	only on corse of	each line.	1.	10, 110 1110 10	aying, sasir	ao varaido	or respiratory a			Inter	val Between et and Death
disease or conditio resulting in death)		a. Due l	cu a	مردم							420	en
		Due	O (or as a cor	sequence of):						9		
Sequentially list co	nmediate	b. Due t	o (or as a cor	nsequence of):							4.00	1->
Cause (Disease or that initiated events	injury						7					
resulting in death)	Last	Due 1	o (or as a cor	sequence of):								
		d										
IF FEMALE:		T							1			
23b. Was deceden			outcome pf properties		□Ectopic pregn	ancv			100	23d. Date o		
in the past 12 1 ☐ Yes 2 [□No		gnant at time		Other (specify					Month	ı Day	Year
9 Unknown			alandh bud and			-11	4.1	00 - Bida				- () - 112
Part II. Other signi	ncant condition	ons contributing to	death but not	resulting in the L	indenying cause	given in Pai	πI.	23e. Dia t			ute to the cau □ Probably	se or deatn? 4 □Unknown
									165 2	اد خلالها	Probably	4 DOTIKTOWN
								24a. Was auto	DSV	pric	or to completic	idings available on of cause of
								1□ Yes	ormed? 2 ☑ No	dea 1 L	ith?]Yes 2□ N	io
25. Was case refer examiner?	_	Hospital:				O46		h (Check only o		-		
1 ☐ Yes 2 ☐ 27. Manner of Deat		1 11	☐ Inpatient te of Injury	2 ER/Outpatie				ome 5 Resi			(Specify)	
1 🖳 Natural	5 ☐ Pendin investig	g (M	onth, Day Yea			Injury at Work? 1 ☐ Yes 2	1	28d. Describe	now mju	y occurred		
2 ☐ Accident 3 ☐ Suicide	6 ☐ Could i	not be	ce of injury - /	At home, farm, st				28f. Location (Street an	d Number	or Rural Rout	e Number
4 ☐ Homicide	determ	bu	lding, etc. (Sp	At home, farm, st pec <i>ify)</i>	, , , , , , , , , , , , , , , , , , , ,			City or To	wn, State)	01 710101	e riamour,
29a. Certifier (Check only		ng Physician: To t Examiner: On the	basis of exam									ause(s)
one) 29b. Signature and	title of cortific		anner stated.		29c 1 ir	ense numbe	er		29d Da	te signed /	Month, Day, 1	(ear)
230. Signature and	2 Certifie	1				7 (?	7	0	zou. Dai	⊸ sigri⊕a (/	vroinn, Day, 1	cai)
	/0	111	-			2/	14	/	10	1141	07	
30. Name and addr	1.1	DI	use of death	(Item 23a) (Type,	Print)	D.	<	in liels		. ^	1 -	10x11
31. Date filed (Mon		Kobin.	Registrar's S	ignature	CIVI	LITY	e. C	TLUS K	יטת	11	w a	120%
,	10V 1		Marie	signature	barte							
	TO Y T		-	/)								

State

Registrar

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			1 - For State Registrar	St	ate of M	1arylar				ealth a Death	and M	ental Hy	giene Reg. No	ר חחכ	38	3356	
	Dharaisi		1. Decedent's Name (First, Middle	, Last)								2. Date of Dea	ath		3. Tim	e of Death	
	Physici /Medio		Donald Warr	en Ho	rine							Novembe	er Î	$4 2\mathring{0}\overset{\text{def}}{0}$	7 5	:20P M	
	Examin	er	4a. Facility Name (If not institution 13908 Pennsy1v	-				4b. City		Location o			4c. Wa	County of Dea	on Co	unty	
	Funeral Director		5. Social Security Number 217–09–9859	6. Sex 1 ፟ M ∶	7. A	ige (In yrs.	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under a	Min.	8. Date of Birt (Month, Da) August	th y, Year) 30	^{9. ві} 1924 Г	Birthplace (State or Foreign Country) Maryland		
	ryland how		Usual Residence of Decedent 10a. State 10b. County			10c. Ci	ty, Town or Lo	_								e City Limits	
	within 72 hours after deeth with the Maryland ene. Than "natural", or iteme 28e or 28e-f ehow the Marical Examiner must be motified at	Funeral Director	Maryland Washi	lager	Code	<u> </u>			10- 00	1 ☑ Yes 2 ☐ No Citizen of What Country?							
	h with	al Dir	13908 Pennsylvan		101. 21		21740		rog. Citi.	U.S.A.							
	r deer	Iner	11. Marital Status	J.S. 13.	Was Dece	ident of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	- 1	14. Race - American Indian, Black, White, etc.						
980	urs afte	þ	1 ☐ Never Married 2 ☐ Marri 3 🖾 Widowed 4 ☐ Divorced	? 1 <u>5</u> 9–2 :12–1(43	1 □ Yes	37	Specify:	,	, σ,	1	Specify: W					
2-0	72 hor	eted	15. Decedent (Specify only highes	16a. Dece	dent's Usu	al Occupa	ition Juring most	of working	20	16b. Kir	nd of Busines	s/Industry					
2121	er than "	Completed	Flementary/Secondary (0-12) College (1-4or 5-)						Dire) -	Or WORK	ig .	Sand Blasting Mfg.				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Dapartment of Heelih and Montal Hygiene. Important: If term 27 is marked other than "natural; or iteme 23e or 28e-f show eny injury or other treumatic event, the Macinal Examinar mant be notified at once.	å	17. Father's Name (First, Middle, I Clayton John Hor				Lau	ura (ne G	Green Horine						
Mar	and 2 shi eith and 27 is m		19a. Informant's Name/Relationship (Type, Print) Linda R. Berg - daughter 19b. Mailing Address (Street and Number of 7542 Watersilk Drive									Route Numbe	Par	k, FL	Zip Code) 33782		
nore,	ages 1 e nt of He n: If item / or othe		20a. Method of Disposition 1 Burial 2 Cremation		al from State	а (Place of Dispo	natory or o	other place			ate			or Town, State		
Baltimore,	permit. P Dapartme Importeni eny injury pnce.		Smithsburg Crematory 11-19-2007 Smithsburg Ma 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral 1331 Eastern Blvd. N. Hagerstown Marylan										_	_			
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												mate		
	Physician /Medical														ind Death		
	Examiner		Sequentially list conditions														
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ривпов от).													
8760,	cata be executed physicien end the burial-transit		resulting in death) cast	quence of):													
	entifica ing ph e as th	Med	IF FEMALE:]							
P.O. Box	w requires thet the daath certific been signed by the ettending p should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic p Other (s)					23d. Date of delivery Month Day Year			Year				
	The law requires thet the site has been signed by thoaga 2 should be detached.	by	236. Did to										obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Minknown				
	The larate has	Completed	-	pe					s an oppy prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Honeit	a la				100	26. Place of Death Check only one)							
on of	this aldii	lon: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Naturat 5 ☐ Pending		al. 1 ☐ Inpat a. Date of In (Month, D	jury	28b. Time of Injury		28c. Injury Work	at ?	2	ne 5 Resid			ecify)		
Division	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be					M 1 ☐ Yes 2 ☐ No eet, factory, office				Street and vn, State)	Rural Route I	Number,		
	Hospital or 24 hours afte Funerel Dire tely filled in t	edical Ce	(Check only 2 Medical t	:xamıner: (In the basis	of examina	wedge, death	o senumed	at the tin	e, date and inion, deat	d place a	nd due to the o	rause(s) date and	and manner a	e stated.	se(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	a	and manner s	stated.			vestigation, in my opinion, death occurred at the time, date 29c. License number 29d.						1. Date signed (Month, Day, Year)		
)	r s r ő	1/3	•		es	2							11-19-2007				
754	129+1	12	30. Name and address of person was Khalid Was	eem :	1126 0		n 23a) (Type, Court H		stown	Mary	1and						
	Sta Registr		31. Date filed (Month, Day, Year)	2007	32. Regis	trar's Signa		rante	j								

State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month James Leonard Howard 14, 2007 November 7:00 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 107 Choptank Terrace Cambridge Dorchester 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Jan. 24, 9. Birthplace (State or Foreign **Funeral** Year) 1918 1 M 2 □ F Maryland 214-07-8338 89 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examine must be notified at Dorchester Director Cambridge 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Choptank Terrace 21613 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white à 3 Widowed 4 ☐ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accountant state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip C. Howard Ola Shenton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health an
Important: If Item 27 is
any injury or other trau Herbert Dorman III nephew 1300 Glasgow St., Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 11/16/07 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. e of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown sign**e**d b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy certificate **3**□No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 2 No Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 4 In Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation To the Function after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ce 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

State of Maryland / Department of Health and Mental Hygiene 2007

Registrar Regi 38358 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician John Vernon Keithley November 1202 P M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital Ceci1 E1kton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min. Director 215-12-0549 88 April 15, 1919 Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Cecil Elkton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with all Hygiene. 1 Colonial Manor Court 21921 Funeral United States 12. Was Decedent Ever in U.S.
Armed Forces? WWII
1♥ Yes 2□ No
If Yes, Give
Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 11 Assembler/Inspector permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If Item 27 is marked other any Injury or other traumant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles King Keithley Reba M. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Stoltzfus/Daughter 12 Walnut Drive, Kirkwood, PA 17536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 24, 2007 Elkton, Maryland_ 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton St., Elkton, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CAVLIAC Arr Ly Huna disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Je12V14 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, CERTIFICATION APPROVED BY MEDICAL EVA resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> for Hiatal Hernia with Complications 2 X No cate has been significant cate page 2 should t 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2\Q\No this certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Yes -Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 1241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year) NOV 3 0

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 12, 2007 Octavia Ε. 8:10 P M Kinsey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert County Nursing Center Prince Frederick Calvert 8. Date of Birth (Month, Day, Year April 27 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 1919 Arkansas 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 J 88 299-22-6459 Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Ex. miner must be notified at 1 ☐ Yes 2 ➡ No Director Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Clay Hammond Road 20678 United States filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Specify: 1 ☐ Yes 2 ☐ No Specifyhite 3 N Widowed 4 □ Divorced Medical Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien Important: If them 27 is marked other the any injury or other trainmant. unknown child care day care center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Goodner Bertha Pope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20678 19a. Informant's Name/Relationship (Type, Print) Patricia S. Roberts-daughter 720 Clay Hammond Rd. Prince Frederick MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐Removal from State Peak cemetery Nov 19 2007 Cyrstal SpringsAk 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Kausch 405 Broomes Island Rd., Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Taral-**Physician** /Medical s a consequence of) Examiner DA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed 1019-17 and burial-trar Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy forι in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other /specify the 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 1□ Yes 2☑No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: ٩ 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Registrar

MD Hospital rd. Prince Frederick MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

Mathur,

Manoj

Division or Vital Records,

Director: filled in by Hospital or within 24 hours a To the Funeral [

Lew 10+1 State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tardio, MD 14090 Solomons Island Road, Suite 310, Solomons, MD 20688

🖭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

047610

29d. Date signed (Month, Day, Year)

November 13, 2007

31. Date filed (Month, Day, 32. Registra Signature 1 4 2007

and manner stated.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Patrick Joseph Kearney 11:30A M November 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2□ F 202-05-4228 87 Director Ireland April 17,1920 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Maryland Charles Charlotte Hall 1 ☐ Yes X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12010 Eastview Lane 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943— 1 Mayes 2□ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White ģ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Federal Government Pages 1 and 2 should be filed vent of Health and Mental Hygiciant: If Item 27 is marked other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. Kearney Sarah Mulhall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Minnick/daughter 12010 Eastview Lane, Charlotte Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 4 □ Donation 5 □ Other (Specify) Nov. 24, 2007 Yeadon, Pennsylvania 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service L 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** DEPENDEN DIABETES MELL SULIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner VASCULAR moni c Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes usease 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Com au 2. No 1☐ Yes 2 🖵 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: ဥ 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 TYes 2 TNo investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of death (Item 23a) (Type, Print) 30. Name and address of person who cor Rince Frederick, MI

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12 **Physician** JUNE M. KELLY NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 153-20-8183 81 JUN 24,1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland 10a. State 10c. City, Town or Location 10b. County nt of Health and Mental Hygiene. If flem 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 VILLAGE ST., APT. 47 21601 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 GEORGE LA CARTY PHYLLIS DAOUPHARS 19b. Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) F. KELLY/HUSBAND DONALD 10 VILLAGE ST., APT. 47, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR 11/14/2007 STEVENSVILLE, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility FELLOWS, HELFENBELN & NEWSTAND 21601 200 S. HARRISON ST EASTON, MD 21601 HELFENBEIN & NEWNAM FUNERAL HOME PA 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** rentricular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 24a, Was an 24b. Were autopsy findings available prior to completion of cause of 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar 31. Date filed (Month, Day, Year,

Micher

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certifier

Matthew

Matheur

ZMartin MD strar's Signatur

29c. License numbe

1601

29d. Date signed (Month, Day, Year)

death?

2007

23:39

Birthplace (State or Foreign Country)

WHITE

NJ

1 X Yes 2 □ No

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

3 Probably 4 □Unknown

20 No

minutes

Year

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Diane Marie Kohan /Medical November 20076:18 13 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing Home Worcester Berlin 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/22/1957 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours 49 **Director** 168-48-8570 PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner πust be notified at Director 1 ☐ Yes 2 XNo MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Candytuft Lane 21811 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Tasty Banking Co. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Stephen Kohan Dolores Stefanick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Kohan / mother 400 Randolph St., Ebensburg, PA 15931 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 11/14/2007 Frankford, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** teestatte disease or condition resulting in death) cers /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examin sician and burial-transit be executed Due to (or as a consequence of) P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death
9□Unknown Month Day Year 5 Other (specify) detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy this certificate No al or Attending Physician: 's after death.
al Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the P within 2, To the P 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

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ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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NOV 1 5 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#19aper FH11/20/1/ Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene State of Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jacqueline Y. Knovick 3, 2007 2250 /Medical Nov. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 72 Days Hours 1 M 2 ₽ F 235-52-6995 Director 24, 1934 West Virginia Nov. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shor 1 ☐ Yes 2√ No Directo Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death wi tal Hygiene.
d other than "natural", or Items 23a of went, the Medit al Examiner must by 20886 19310 Clubhouse Road Apt 512

11 Marital Status 12. Was Decedent Ever in U.S. by Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Assistant</u> Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked otl Wildy Shepherd of Health and Menta Item 27 is marked rother traumatic ev Catherine Tilda Adkins 19a. Informant's Name/Relationship (Type. PrinGuardian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie FInk - Ciardian 200-A Monroe St. Rockville, MD 20850 Ste. 200 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If Ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 11-19-07 | Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signatur of Furral Service License 1040 Rockville Pike, Rockville, MD_20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical 3 Days Due to (or as a consequence of) Examiner Coronary Artery Disease 3 Days Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-transit Probable Thromboembolism 3 Days Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical Atrial Fibrillation Paroxysmal Years 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1∐Yes 2∏XNo ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No al or Attending Ph s after death. al Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 6, 2007 22846 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Robert Di Bianco, MD 31. Date filed (Month, Day, Year)

NOV 1 5 2007

32. Pegistrar's Signature

15215 Shady Grove Road, Rockville, MD 20850

ORIGINAL

Da'Quonna Darnyell	l Kiah 1- For Sta		te of Maryland				Mental	Hygiene	000	
Di cirica d	Registrar		(got)	Certi	ficate of	Death		2. Date of Dea	eg. No.	3836
Physician/ Medical Examiner			_	1011	V	1-		Month November	Day Year	3. Time of Death 0635 hrs
and a co	1	ity Name (if not institution,			41	o. City, Town, or L	ocation of De		4c. County of Deat	h
	Rou	ite 318 @ Lovers Ro	oad			Federalsburg)		Dorchester	
Funeral	5. Social	Security Number 6.	. Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year				rthplace (State or Foreign buntry)
Director	220	11-2324 1	1 M 2 F	2	/ Yrs.	Months Days	Hours	Min. Mal/	10 100.1	1aryland
*	Usual Re	esidence of Decedent		Les au =						/ -
w any	10a. Stat	te 10b. County			own or Locatio					10d. Inside City Limits 1 Ves 2 No
Maryland 28a-f show d at once.	/VI	D Talb eet and Number	oot	7	rapp	10f. Zip Code			log. Citizen of What Cou	
11215-0036 Id be filed within 72 hours after death with the Maryland dental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. O Be Completed by Funeral Director			1		1				7/ / A	intry?
ith the size and size		665- Bac tal Status	Ktown 12. Was Decedent	Roac Everin IIS	13 Was		673	(Specify Yes or No	U S /	rican Indian, Black,
net be gath Q		lever Married 2 Marr	ried Armed Forces		If Ye	s, specify Cuban,	Mexican, Pu	erto Rican, etc.)	White, etc.	rican indian, black,
Fr., or V. F.	3 V	Vidowed 4 Divor	ced If Yes, Give Year	No	1	Yes 2 1 No	specify:		Specify: R	ack
ours aft atural" xamine	15. De	cedent's Education (Specif	y only highest grade cor	mpleted) '		s Usual Occupation			16b. Kind of Business	/Industry
6 172 h an "n cal E	Eleme	entary/Secondary (0-12)	College (1-4 or	5+)	during mo	st of working life.	DO NOT use	retired)		
5-0036 ed within 72 hour sygiene. other than "natu the Medical Exan	17.5	12	<u> </u>		130	enk to	eller		Bani	K
215- be filed ntal Hyg rked oth ent, the		er's Name (First, Middle, L		11-1		1		ame (First, Middle,	Maiden Surname)	
ore, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		ormant's Name/Relationship	p (Type, Print)	iah,	19b. Mailing	Address (Street	Teil and Number	or Rural Route Nu	mber, City or Town, Stat	te, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic	TE	zila Pott	Ler Mille	e h					trappe, Ma	2 11, 73
Fe, Land I and Healt Fitem	20a. Met	thod of Disposition		20b. Pl	ace of Disposi ematory or oth	ion (Name of cem	etery,	Date	20c. Location - City of	r Town, State
More Pages 1 ent of H int: If it		Junial 2 Cremation Conation 5 Other Spec			,	Cemete	1011	1/17/07	Thappo 1	Naryland
mit.		ature of Funeral Service Li		710						10191010
E B B B E		tanelle C	. Henre	2	He	NRY FUN	seral r 10 Was	hington S	ti Cambrid	ac.MD.21613
Physician		t I. Enter the disease, or co ure. List only one cause or		he death. I	Do not enter th	e mode of dying, s	such as cardi	ac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		ate Cause (Final disease	a. Multiple Injuries							Death
\$1		ition resulting in death)	Due to (or as a cons	equence of):	:					
Je Je	Sequent if any, le	tially list conditions, eading to immediate	Due to (or as a cons	equence of)						
red nsit Examiner	cause. (Disease	Enter Underlying Cause e or injury that initiated	c. Due to (or as a cons	oguenee of						-
uted ansit		resulting in death) Last	d.	requerioe or,						
to, e be executed ysician and burial - transit	U	NPENDED	AMENDED					.=		
760, cate be physici he buri.			23c. If yes, outco	me of pregna	ancy				23d. Date of delive	ery
6876 certificate nding phy se as the t	23b. Was pasi	s decedent pregnant in the table 12 months?	Live Dittil	t time of dea	=	al death 3	Ectopic pre	egnancy	Month	Day Year
D. Box 6876 the death certificate by the attending phy ched for use as the b	1 Y	es 2 No 9 V Unkn		t time of dea	^{tn} 5Oth	er (Specify)				
		Other significant conditio	ns contributing to dea	th but not res	sulting in the u	nderlying cause gi	iven in Part I.	23e. Did	tobacco use contribute t	to the cause of death?
ires that signed libe deta								_ 1 _ Ye	es 2 No 3 Pr	obably 4 🗸 Unknown
Records, The law requires frate has been signate the been signated by Completed								24a. Was		autopsy findings available ocompletion of cause of
ecc he lav ate ha									ormed? death?	
tal Rician: T certific ector, p		case referred to medical						eck only one)		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rist after death. Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	- 1	niner? Yes 2 No	Hospital: 1 Inpati	ent 2 🔝 i	ER/Outpatient	3 DOA	Other N	ursing Home 5	Residence 6 🗸 Oth	er: Scene
ing Ph After t funeral		ner of Death Natural 5 Dendin	28a. Date of Inj (Month, Day, FOUND:	ury Year)	28b. Time of Ir FOUND:		y at Work?	Driver auto	how injury occurred of fixed object collis	ion
Sion Mitend death. ctor: yy the f	2 🗸	J Feridii	igation Nov 10, 200	7	0631 hrs		es 2 ✔ No			
Division or spital or Attending tours after death. neral Director: After filled in by the fune. Certification:	3 🗌 :	Suicide 6 Could	not be		ne, farm, stree	t, factory, office bu	uilding, etc.	or Town,	State)	Rural Route Number, City
C Till For		rtifier 4 Continue Bu	(Specify) St		a dooth accur	and at the time de	to and place	- 1	Lovers Road, Fede	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification; To Be Com	(Check or one)	nh I Certifying Fify	iner: On the basis of exa	amination an	e, death occum d/or investigat	on, in my opinion,	death occur	ed at the time, date	e and place, and due to	the cause(s)
To con	29b. Sig	nature and title of certifier	and manner stated			29c. License			29d. Date signed (A	
	P	t () -	-P00			O.C.N	И.E.		November 11,	2007
	30. Nam	ne and address of person w	who completed cause of	death (Item :	23a)					
		ricia Aronica-Pollak	-101			111 Penn Str	reet, Baltir	more, MD 212	01	
State Registra		e filed (Month, Day, Year)	5 2007 32. Registra	ar's Signatur	H A					

ORIGINAL

State of Maryland / Department of Health and Mental Hygieneo

			1 - For State Registrar	State of Maryland		tificate of			eg. No.	38366
	Physicia	an	1. Decedent's Name (First, Middle, Last					2. Date of Deat	h	3. Time of Death
	/Medic	al	JAYDEN	KURTZ		4h Cihi Toum o	r Location of Death	NOVEMB	4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give Saint Joseph	Medical Cen	iter	40. City, Town, o	Tows	on	,	ltimore
a a	Funeral Director		5. Social Security Number 6. Se	X 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. スを	8. Date of Birth (Month, Day, November		rthplace (State or Foreign country)
	and ww.		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryl t-f sho	tor	maryland Baltimo	RE PI	arkvi	lle				1 □Yes 2 No
	th with the	al Dire	10e. Street and Number 6620 English 0.4	k Road Apt	. C	10f. Zip Code	1234	1	Og. Citizen of What C	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☐ Yes 2XNo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: (
2-0	72 hou nature lical E	eted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occup	oation during most of worki d)	ina I	16b. Kind of Business	s/Industry
21215-0036	ed within 7/giene. er than "i the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	Infan	t		Infa	nt
Maryland	ould be file Mental Hy larked oth latic event	To Be	17. Father's Name (First, Middle, Last) DANIE! KUR	2			18. Mother's Name	,	***	÷ A
Mary	nd 2 shol aith and N 27 is ma r trauma		19a. Informant's Name/Relationship (T) DANIE + L AUREN K	urtz (PARENTS)	19b. Mailir	g Address (Street	OAK ROAD	Apt. C	, City or Town, State, PARKVILLE	Zip Code) , mD, ZIZ3Y
Baltimore,	Pages 1 and 2 nent of Health int; if item 27 i		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	20b. Pl	ace of Dispo emetery, crer	sition (Name of matory or other plan EEMER	ce) Apr.		20c. Location - City of	r Town, State C.ty, MARY/AND
Baltir	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licens	see	S 22	Name and Addre	ess of Facility medical C	ENTER	7601 OSIGN	DRIVE
	Physician /Medical Examiner		23) Fart Enter the disease, or composite k, or heart failure. List only of imprediate Cause (Final disease or condition resulting in death)	licities that caused the death one cause on each line. EXTREME For Due to (or as a consequence)	REMAT		ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	rificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequ c. Due to (or as a consequ d.	,					
Box	death cer e attendir d for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
, P.O	s that the property of the pro		Part II. Other significant conditions co	ontributing to death but not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
rds	requires that the sen signed by the	ed p	MOTHER USED COCA	INE/HEROINE 4	DAYS	AGO		1 □ Ye	es 2□No 3□I	Probably 4 Unknown
Il Records,	The lar ate has page 2	Completed by						24a. Was a autops perform 1□ Yes	y prior to	autopsy findings available completion of cause of
or Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		. all poal Oth	26. Place of Death			·
o	Phys r this ral dir	To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	IL 3LI DOA	4 LI Nursing Ho		ence 6 Other (Sp ow injury occurred	ecify)
ion	ath. r: Afte	ation	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No			
Division	cal or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hos building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town	treet and Number or i n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 ★ Certifying Phy (Check only one) 2 ★ Medical Exam	vsician: To the best of my know Iner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	n occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within comp	M	29b. Signature and title of certifier	/2	MI	D21	e number . 8217		9d. Date signed (Mo	
*	BH.		30. Name and address of person who o				OWSON. I	MARYI AN	VD 21204	

State Registrar

31. Date filed (Month, Day, Year) NOV 3 0

32. Registrar's Signature

			For State	State of Ma	ryland / Depa	artment of H			0000	00007
			Registrar	ent)	Cel	Tillicate of t	Dealli	2. Date of Death	. No.	3. Time of Death
	Physicia	an ⊱	1. Decedent's Name (First, Middle, L					Month	Day Year	M
	/Medic	al	Patricia	Louise	Lippinco		r Location of Deat		20, 2007 4c. County of Deat	3:30 p.m.
	Examin	er	4a. Facility Name (If not institution, g					·	,	
5	·		22438 Greenvi 5. Social Security Number 6.		(In yrs. last birthday)	Great If Under 1 Year	M111S If Under 24 Hrs.	8. Date of Birth	St. Mar	hplace (State or Foreign
м	Funeral Director		154-22-0718	1□M 2\\ F	75 Yrs.	Months Days	Hours Min.	Jan. 16.	(ear) Co	untry) Jersev
			Usual Residence of Decedent		_/3			ψан. 10,	1932 New	Jersey
	yland iow at		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mar a-f sh fied	햐	Maryland St.	Mary's		Great	Mills			1 ☐ Yes 2 📉 No
	with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What Co	untry?
	h with		22438 Greenvie	W		20	0634		United St	ates
	deat ms 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, White	rican Indian,
9	after or ite mine	F	1 Never Married 2 Married		0	1 □ Yes 2 🔯 No		,	Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	l by	3 ☐ Widowed 4 X Divorced	Year or Dates:						
2-0	72 h	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usual Occup kind of work done	during most of wo	rking 10	6b. Kind of Business/	Industry
7	within iene. than " he Med	ם	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired	•		Gamins	-
7	filed w Hygier ther th		12		Casin	o Supervi		me (First, Middle, Ma		3
pu	should be filed of Mental Hyging marked other matic event, t	Be	17. Father's Name (First, Middle, La	st)				, ,		
yla	should be fand Mental s marked of	မ	Pete Previti		1			<u>icia Prev</u>		7: 0: 1:1
Maryland	S S S		19a. Informant's Name/Relationship		1				City or Town, State, 2	
	E E N L	1 3	Thomas Kracinovio	h/Son-in-la			w Court,		IIs, Mary. Oc. Location - City or	Land 20634
Baltimore,	of of fir		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐Removal from State	1	matory or other pla	1		,	
<u>E</u>	e e ∺ ≥		4 ☐ Donation 5 ☐ Other (Spe	cify)	Brinsfiel	d-Echols	Cr. 11-2	1-2007 C	harlotte I	Hall, MD
alt	permit. F Departm Importar any injui		21. Signature of Funeral Service Lie	ensee					Funeral Ho	
Ш_	8 3 E % 5		Kyle S. Sir							20650-0279
71			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused ly one cause on each lin	the death. Do not en e.	ter the mode of dyli	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	CAPL	MAC AR	AYTHM.	1A5.			Oliset and Death
1	/Medical		resulting in death)	Due to (or as a	a consequence of):	- 0 - 1	0			11000
	Examiner		Se ventially list conditions	b	1/EMIC (AHLDTUN	140) 14 14	17		YEARS
	7 +	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence oi).	. / - 5	77. 11. 11	malan A	- (5-12	V/A
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	C	10 OBST	CVCIIVE	POUM	0307574 9	71075	THING _
Ö,	cate be executed physician and the burial-transit	m	resulting in death) Last	Due to (or as	a consequence of):					
8760,	ate be nysici he bu	dical	•	d						
မွ	death certifica attending ph I for use as th	Med	IF FEMALE:							
Box	th ce tendi r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		⊒Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
	e dea ne att ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _			World	Day Tour
P.0	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	Physician/Me	9 Unknown					an Billion		
S,	signed be det	by F	Part II. Other significant condition	s contributing to death be	it not resulting in the u	inderlying cause giv	ven in Part I.			o the cause of death?
Division or Vital Records,	w require been sign	ed						1 L Yes	3 2 □ No 312 P	robably 4 □Unknown
သို	aw re is be 2 sho	plet						24a. Was an autopsy		utopsy findings available completion of cause of
ď	hysician: The law hi s certificate has I I director, page 2 s	Completed						perform	ed? death? □No 1 ☐ Yes	_
ţa		Be C	25. Was case referred to medical				26. Place of De	ath (Check only one		
>	Physician: this certific al director,	0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3□ DOA Ott	her: 4 \sum Nursing	Home 5 Resider	nce 6 Other (Spe	ecify)
0	ding Ph	Ë	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time (Year) Injury	of 28c. Inju Wo	ry at	28d. Describe how	w injury occurred	
0	Attending r death. ector: After oy the fune	atio	1, Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	,,		Yes 2 □ No			
Vis	Atte	ij	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of inju	iry - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	lural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Certification:								
	ospil hour uner)al	29a. Certifier 12 Certifying (Check only 2 Medical E	Physician: To the best	of my knowledge, dea	th occurred at the t	ime, date and place	ce, and due to the ca	use(s) and manner a	s stated. te to the cause(s)
	the H in 24 he Fi plete	edic	one)	and manner sta						
	To t To t	Ž	29b. Signature and title of certifier	,		29c. Licen			d. Date signed (Mon	
	Δ.		12 J CW	<u> </u>	M	> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	6096		11-21-	07
	()~		30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type	, Print)	C. 60	So line	N. Jack	07 MD 20050
	711		RAJBINDER			MAH A	SOCIAT	TS HOL	COOMI	MD 20050
		ate	31. Date filed (Month, Day, Year)		ar's Signature					
	Regist	rar	NOV 2 1	ZHH7 Allen -	Marie Marie					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Registrar 20b, FH, TCHD, 11/15/07 pha

1. Decedent's Name (First, Middle, Last)

Tane Personal State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38368 1 Month **Physician** Jane Bradley Lowe 9:30 p 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Hospice House Easton

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Easton Talbot 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Months Days 216-30-4257 07-31-1931 Washington, 76 Yrs. Director Usuel Residence of Decedent death with the Maryland th and Mental Hygiene. It is marked other than "natural", or Itama 23a or 28a-f ahow traumatic avant, the Medical Examinat must be cotified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Talbot 1 Yes 2 □ No Director Md Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 586 Cynwood Drive 21601 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) elemtary School 11 Years 4_ Teacher years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Reed Bradley Gertrude Dotson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 la any Injury or other trau John V. Lowe (son) 59 Washington Rd. Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 11/12/2007 -12-200 Dover, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Capitol Crematory 11 21. Signature of Funeral Service Licensee me and Address of Facility
Carroll Hurley Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 21663 Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) M it a static Branchagenic Cusainan Spet and -**Physician** /Medical Due to (or as a consequence of): Examiner 00V 2~4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): Due to (or Examine law requires that the death certificate be executed attending physician and for use as the burial-transit COPD 104 Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) by the a 9 Unknown signed b Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 4 own Completed le obcrosi 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform S 95001 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 04 ပ္ 1 Tes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760. or Attending Physician: after death. To the Hospital within 24 hours a

Medical

State Registrar

29a. Certifier

10

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier 0 1000 Lone

D 600 9034

29d. Date signed (Manth, Day, Year) 11 01)

who completed cause of death (Item 23a) (Type, Print)

Robert M. McDonald, MD. 30 E. Dover St., Easton, Md. 21601

ģistrar's Signature

Phy /M Exa

Fune Direc

certificate be executed	M- ka	m	se as the burial-transit
in: The law requires that the death of		ificate has been signed by the attend	or, page 2 should be detached for us
To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	•	For State Registrar				rtificate of L			Reg. No	007	38369
Physicia		Decedent's Name (First, Middle KATHRYNE		LECHLID	ER			2. Date of Dea		2007	3. Time of Death 11:25A M
/Medic Examin		4a. Facility Name (If not institution FREDERICK MEMO	-			4b. City, Town, or		h		unty of Death	
uneral irector		5. Social Security Number 215-66-6717		7. Age (In yrs. la.	st birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 11	, Year)	Coul	place (State or Foreign ntry) aryland
show ed at	٥ř	Usual Residence of Decedent 10a. State 10b. County Md . Can	croll	10c. City,	Town or Lo	cation Airy					10d. Inside City Limits 1 ☐ Yes 2 🗷 No
a or 28a-1 t be notiff	Director	10e. Street and Number 4321 Ridge Dri	Lve			10f. Zip Code	21771			of What Coun	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deced	2⊠ No e		Uwas Decedent of Hi lf Yes, specify Cuba 1 □ Yes 2 ☑ No		pecify Yes or No- to Rican, etc.)	14.	Race - Americ Black, White,	can Indian,
han "natu Medical	Completed	(Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-	4or 5+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking		of Business/In	·
c event, th	Be	12 17. Father's Name (<i>First, Middle,</i> James D. I	0 			account As	18. Mother's Nar	ne <i>(First, Middle,</i> irginia			cnools
27 Is mari traumati	<u></u> 2	19a. Informant's Name/Relations Charles J. Lech		Husband		ng Address <i>(Street a</i> 321 Ridge	and Number or R	ural Route Numbe			771
nt: If item ry or other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from S	20b. Pla	ce of Dispo metery, crei	sition (Name of matory or other place	е)	Date /21/07	20c. Locati	on - City or To	
Importa any Inju once.		21. Signature of Funeral Service	Licensee	her		2. Name and Address Muriel H	s of Facility Barber		Home		
sician edical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	ch line.	lar	er the mode of dyin		c or respiratory ar	rest,		Approximate Interval Between Onset and Death
miner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. CAI	CDIUM or as a conseque	YUPA	THY					
physician and s the burial-transit	ledical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (c	or as a conseque	ence of):						
To the Funeral Director. After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		rth 2 ☐ Fetalo ant at time of dea	leath 3	Ectopic pregnancy			23d	. Date of deliv Month	ery Day Year
n signed by	ed by Pr	Part II. Other significant condition				nderlying cause give	en in Part I.	23e. Did to			he cause of death? bably 4 □Unknown
ate has beє page 2 sho	Completed by	BRUNCHIE	CTASIS					24a. Was autop perfo 1∐ Yes		prior to co death?	opsy findings available ompletion of cause of
s certifica lirector,	o Be (25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2□E	R/Outnatier	nt 3 DOA Othe	ar.	ath (Check only o	ne)	10th -= (Ci	4.1
or: After this the funeral o	Certification: To	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date o (Month gation		28b. Time o Injury	f 28c. Injun Work		28d. Describe h			<u>19/)</u>
ral Direct led in by	Certifi	4 ☐ Homicide determ	nined 28e. Place of buildin	g, etc. (Specify)		eet, factory, office		City or Tox	vn, State)		al Route Number,
the Fune	Medical	(Check only one) Medical	ng Physician: To the I Examiner: On the ba and mann	sis of examination	ledge, deat on and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and pla	ace, and due t	to the cause(s)
T 000	~	29b. Signature and title of certifie	MD				06349				,
)		30. Name and address of person LAKHVINI 31. Republic Mark Park Soul	FR WA	DHWA	400	Print) W. 7th	Street,	Frederic	k, Md	. 2170	01
Sta Registr		31. Date filed (Month, Day, Year)	1 9 2007 Þ	gistrar's Signatu		Sperte					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Kelly D. Legion Nov. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Montgomery

9. Birthplace (State or Foreign Country) <u>Washington Adventist Hospital</u> Takoma Park If Linde 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) Days 1**X** M 2□F 577-08-3342 Jan. 15, 1967 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Washington, DC DC None 10e. Street and Number 10g. Citizen of What Country? 2300 Good Hope Road, S.E. #1010 20020 USA 2. Was Decedent Ever in U.S.
Armed Forces?

↑ Yes 2 No
If Yes, Give
Year or Dates: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ YNo Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Professional Driver</u> Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Legion Lincoln Nixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2300 Good Hope Road, S.E. #1010 Washington, DC 20020

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State Wendy S. Legion/Wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 11/16/2007 Riverdale, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th Street, NW, Washington, DC 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ccuired Due to (or as a consequence of): Linas immune if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Sebha Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner Physician/Medical Examiner the death certificate be executed nding physician and use as the burial-tran .O. Box 68760 atten for u Division or Vital Records, P. signed I Be Completed by certificate Medical Certification: To

Physician /Medical

Physician

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the N. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nature." any injury or other traumatic every once.

Funeral Director

Completed by

Be

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/Medical

this After or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 'Year) 5 Pending investigation 1 Villatural 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated.

29c. License number D0060100 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 831 University TAHMINA

State Registrar 31. Date filed (Month, Day, Year)

NOV 15 2007

			•	For State Registrar	State of Ma	aryland		artment of F	Health and M <i>Death</i>	lental Hy	giene Reg. No.		
	P _s	Physicia		Decedent's Name (First, Middle, VENETIA EVA	<i>'</i>					2. Date of De Month	eath Day	2007	3. Time of Peath
6791	9	/Medic Examin		4a. Facility Name (If not institution,	give street and number)	ı ca	pter		or Location of Death		4c. C	county of Death	
90031	253	Funeral Director		5. Social Security Number 221–44–6598	77,00	e (In yrs. la	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 05-09-	ay, Year)	9. Birthp Coun DELAW	
N	100	faryland show ed at	or	Usual Residence of Decedent 10a. State 10b. County PA			, Town or Lo			<u></u>		1	0d. Inside City Limits
Lan		with the Maryland ia or 28a-f show I be notified at	Director	10e. Street and Number 2307 N. LAMBERT	э саргел	11111		10f. Zip Code				en of What Coun	
Venetin	936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Import nt: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ence.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?			Was Decedent of H f Yes, specify Cub l □ Yes 25 No	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or N Rican, etc.)		4. Race - Americ Black, White, Specify: BLAC	etc.
79	21215-0036	d within 72 hougiene. r than "natur the Medical E	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or s	5+)	(Give	OO NOT use retire	during most of worki	ing	I	d of Business/Ind	dustry TY NURSE
	Maryland 2	should be filed ind Mental Hygis marked other imatic event, til	To Be C	17. Father's Name (First, Middle, L TONY GRAY	.ast)				18. Mother's Name			urname)	
		and 2 sho salth and l n 27 is ma ier trauma		19a. Informant's Name/Relationsh EBONY RASHIDA MO	Darror	ITER		,	and Number or Rura				Code)
	Baltimore,	Pages 1 ment of He ant; If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State	CE	emetery, cirei	sition (Name of matory or other pla OF DELMA	ARVA 11-2	Date 24-07		AR, DEL.	·
	Balt	permit. Departimport any Inj		21 Signature of Funeral Selvice	mil)	_			SS OF FACILITY FITH FUNERA MARYLAND		917	W. ISABE	ELLA ST.
4		Physician		23a. Part1. Enter the disease, or o shock, or leart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each li	d the death ine.	Do not ent	er the mode of dyi	ng, such as cardiac o	or respiratory	arrest,		Approximate Interval Between Onset and Death
		/Medical Examiner	1.	Sequentially list conditions, if any, leading to immediate	b		T	В					1
	8760,	cate be executed oblysician and the burial-transit	lical Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
	Box 6	Attending Physician: The law requires that the death certificate be executed death. death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Mec	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ➡ nknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 □ Fetal	death 3	⊒Ectopic pregnand]Other <i>(specify)</i> _	by .		23	Bd. Date of delive Month	ery Day Year
	rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditio	ns contributing to death t	out not resu	ilting in the u	nderlying cause giv	ven in Part I.			_	ne cause of death? ably 4 □Unknown
	al Reco	i: The law recicate has bee	Completed							per 1□ Yes	opsy formed? 2 No	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of No
	Division or Vital Records, P.O.	ding Physiclan: The In. After this certificate hat funeral director, page	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpati	ury	ER/Outpatier 28b. Time o Injury	f 28c. Inju	iry at ork?		sidence 6	☐Other (Specific occurred	у)
	Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	Accident investig 3 Suicide 6 Could n 4 Homicide determine	ation of be 28e. Place of in	jury - At ho tc. <i>(Specif</i> y	me, farm, str	M 1 ceet, factory, office]Yes 2□No		(Street and own, State)	Number or Rura	d Route Number,
		the Hospit in 24 hour the Funera pletely fills	edical		g Physician: To the best Examiner: On the basis of and manner s	of examinat		vestigation, in my	opinion, death occur		e, date and	place, and due to	the cause(s)
		With With Electric Party and Party a	M	29b. Signature and life of certifier	D.0	-		29c. Licen:	se number			signed (Month,	Day, Year)

State Registrar 'ST. SALISHUM MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** isbur WICOMICO If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fo. Country) Pennsylvania Social Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Months 74 198-26-9138 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 K Yes 2 □ No Maryland Directo Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1109 South Schumaker Drive 21804 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Years If Yes, Give Year or Dates: Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XNever Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White à Specify 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Expeditor Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f ment of Health and Mental I ant: If item 27 is marked o Michael Lasky Cecilia Tresnak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Laskey/Sister-in-law #11 Fort Sumpter South, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o 1X Burial 2 □ Cremation 3 □ Removal from State Our Lady of Good Counsel 11/14/2007 4 ☐ Donation 5 ☐ Other (Specify) Secretary, MD 21. Signature of Funeral Service Lidense Zeller Funeral Home, P.O. Box 207 106 Main Street, East New Market, MD 21631 . Enter the disease, or con ck, or heart failure. List only plications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** ARCINDANA LUNGS disease or condition resulting in death) /Medical **Examiner** 0135 CHRENIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine ng physician and as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) I□Yes 2□No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an page 2 s has autopsy perform filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1XINatural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours a

To the Funeral I

completely filled

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CEASTAL

WHORIS

DHMH 17 Rev 1/2001

29c. License number

20052410

ROBER 1733 STUSBURY

29d. Date signed (Month, Day, Year)

		1 - For Amend In Registrar	State of Maryla Lem 20b per	ind / Depa in, g875, Cer	officate of l	ealth and i Inb Death	Mental Hygi	ene 200°	7 38373
Physic /Medi		1. Decedent's Name (First, Middle, Last	un C.	L47	e		2. Date of Death Month NOV	Day Year 8 2007	3. Time of Death 2:50 PM
Examir		4a. Facility Name (If not institution, give Genesis Health)		Pines	•	Location of Death	ו	4c. County of Dea	
Funeral Director		5. Social Security Number 6. Se		rs. last birthday) 3 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Bii	thplace (State or Foreign ountry)
the Maryland	ctor	MD Dorche	ster 10c.	City, Town or Lo	dge 101. Zip Code				10d. Inside City Limits 1 ☐ Yes 2 1 No
\ \{\frac{1}{2} \frac{1}{2} \frac{1}{2}	I Director	10e. Street and Number 1222-Hudson	10 1		16. Zip Code	1.7	10	g. Citizen of What C	ountry?
ler dea	by Funeral	11. Marrial Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l II	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
21215-0036 d within 72 hours aff glene "naturel", or r the Medical Exam.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	ent's Usual Occupa kind of work done of DO NOT use retired	furing most of wor)	king	6b. Kind of Business	/Industry
ryland tould be file tould be	To Be (17. Father's Name (First, Middle, Last) Milbourne		1		18. Mother's Nam	ne (First, Middle, M.	nson	
Gore, Mary		19a. Informant's Name/Relationship (7) Tiha Mee 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ F	Kins	. Place of Dispos	Hudson sition (Name of	Boad C	ambridg Date		nd 21613 Town, State
Baltimore, permit. Pages 1 a Department of Hee importent: If Item eny injury or othe		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Henry	22.	Cemeter Name and Addres ewry Fur	neval Hol	ne, P.A.	idge, M	Maryland Di 21613
1 Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the dene cause on each line.	eath. Do not ente	or the mode of dying	g, such as cardiac	or respiratory arres	st. 99	Approximate Interval Between Onset and Death
/Medical Examiner			Due to for as a cons	equence of):	thy				neers
60, be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to or as a cons	eson	<i>J</i>			•	years
phys	dical	l	d. Atherosc	levosis					years.
at the death certific by the attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
- E 5 5	ed by P	Part II. Other significant conditions co	ntributing to death but not r	esulting in the un	derlying cause give	n in Part I.			o the cause of death?
I HeC	Completed						24a. Was an autopsy performe 1 Yes 2	24b. Were a prior to death? ∴ No 1 □ Yes	utopsy findings available completion of cause of
Of Vita Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3□ DOA Othe		th <i>Check only one</i>	ce 6 Other (Spe	iculu)
VISION OT Attending Physic death. ector: Affer this by the funeral di	Certification: 7	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \(\text{Y}		28d. Describe how		·.,,,
UIVISIO To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	cify)			City or Town,	·	
he Hos in 24 ht he Fun pletely	Medical	(Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my op	e, date and place, inion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner a: e and place, and du	s stated. e to the cause(s)
To the withing To the comp	¥	29b. Signature and title of centrer	ionslay, Md		29c. License	75933	3	1. Date signed (Mont	4
	13	30. Name and address of person who co	omplet cause of death (It	em 23a) (Type, F	rint) , IMANS	LANE	EASTOR		21601
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	A . 0 .			,	

			For State	State of	f Marylan		artment of H				•	200	7 000	0 71 1
			Registrar 1. Decedent's Name (First, Middle,	. Last)		Cei	lillicate of	Dealli		2. Date of De	Reg. No.	200	3. Time of D) Leath
	Physicia		James Edwin M	,						Month 11-25	Day		7:35	рМ
	/Medic Examin		4a. Facility Name (If not institution,		nber)		4b. City, Town, o	or Location	of Death	II 2)		County of Dea		1
			Kline Hospice	House			Mt. Air	~v			Fr	ederic	k	
	Funeral		5. Social Security Number	6. Sex 12 M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Bir	thplace (State or ountry)	Foreign
	Director		198-01-4442 Usual Residence of Decedent		90	Yrs.				11-3-1	917		PA	
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City	Limits
	Mary I-f sh	tor	MD Frede	rick	Fr	ederic	k						1 □ Yes 2	2 X No
	h the or 28e e noti	Director	10e. Street and Number	LICK		CUCLIC	10f. Zip Code				10g. Citiz	zen of What C	ountry?	
	hours after death with the Maryland tural", or items 23a or 28a-f show of Examiner must be notified at		1035 Dulaney M	111 Drive			21702				Ţ	JSA		
	tems	Funeral	11. Marital Status	Armed For		S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)),	 Race - Am- Black, Whi 		
20	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes Giv	2□ No e ates: 41-7	2	1 □ Yes 2] No	Specify.	·:			Specify: T.T.	nite	
3-003p	2 hour		15. Decedent'	s Education	41-/	16a. Dece	dent's Usual Occu	pation		_	16b. Kii	WI nd of Business		
<u>.</u>	hin 72 In "ne M dl	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give life.	kind of work done DO NOT use retire	during mos d)	st of worki	ng	ĺ			
7	d with	Completed	Elementary/occordaty (0-12)	4		U.S	S. Army				U.5	G. Gove	rnment	
and	be filed within 72 hours after death with the Marylan that Hygiene. do other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the M. di-ar Examiner must be notified at	Be (17. Father's Name (First, Middle, L	.ast)				18. Moth	er's Name	(First, Middle	, Maiden	Surname)		
<u>X</u>	2 should be filed within 72 h n and Mental Hygiene. 'is marked other than "natu raumatic event, the M. dica	2	James M. McDowe							E. Mcl				
Ma			19a. Informant's Name/Relationsh		~		ng Address (Street						•	
ປົ	1 and Health em 27 ther tr		Douglas S. McDo 20a. Method of Disposition	well	Son 20b. P		Dulaney			e Frede		cation - City or		
5	permit. Pages Department of I Important: If ite any Injury or of		1 ☑ Burial 2 ☐ Cremation		State		sition (Name of matory or other pla	1				•		
ашшо	artme artme ortani Injury		4 □ Donation 5 □ Other (Sp 21. Signal re of runeral Service C		Sou	ıthlawı	n Mem. Pa	ark : ess of Facili	12-1	-2007 I	Prir	ice Geo	rge, VA	
0	permit Depar Impor any Ir once.		to hall	/ lan	MO1176	110	2. Name and Address O6 East (hurak	Kee	ney & J	Basic	ord P.A	. F.H.	
۲	9 -		23a. Part1. E er the disease, or o shock, a heart failure. List o	complications that ca		n. Do not ent	ter the mode of dyi	ng, such as	s cardiac o	or respiratory a	rrest,	CK, III	Approximate Interval Between	100P
	Physician	e W	Immediar Cause (Final	11211	0.00		Tailure						Onset and De	eath
	/Medical		resulting in death)		or as a consequ		HIJUIL						WELUS	
	Examiner		Sequentially list conditions	b. =										
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):								
) <u> </u>	and I-tran	Examiner	that initiated events resulting in death) Last	c	or as a consequ	lence of):								
9	be ey	alE			or as a corrisoq.	acrice 51).								
00	phys s the	edical	Λ'	d										
XOD	nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out							2	23d. Date of de	liverv	
Ď	death atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	irth 2□Feta ant at time of d		∃Ectopic pregnanc ∃ Other <i>(specify)</i> _	у				Month		ear
Š	t the by the acher	hys	9 ☐ Unknown	9□Unkno	own									
'n	es tha gned se del		Part II. Other significant condition			ulting in the u	nderlyi ng cause g iv	ven in Part	I.	23e. Did 1	obacco u	se contribute t	o the cause of de	_
ecords,	equir sen si ould b	Completed by	Gastrolates	tinal 5	lee ding					10	Yes 2[No 3∏P	robably 4 🗗 Or	iknown
ည်	as be	ple				-				24a. Was		24b. Were a	utopsy findings av completion of cau	vailable use of
	ate h	Con								perfo 1∐ Yes	2 ☐ No	death? 1 ☐ Ye		
בן א	ician sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			O#1		e of Death	(Check only	one)		KLINE	
5	Phys this a		1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of	IL OLI DON			me 5 Resi		6 Other (Spe	ecity) Hespi	
5	ding h. After fune	tion	1 ■ Natural 5 □ Pending 2 □ Accident investiga	(Mont	h, Day Year)	Injury	Wo	rk?]Yes 2□		EGG. DOSCRIDO	now injur	y occurred	NOU	7] [
7	Atten deat ector:	Certification:	3 Suicide 6 Could no	ot be 28e. Place	of injury - At ho	me, farm, str	eet, factory, office			28f. Location (Street and	d Number or F	Tural Route Numb	er,
5	al or after al Direction of an b	erti	4 ☐ Homicide determin	builder	ng, etc. (Specify	V)			- 4	City or To	wn, State,)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			Physician: To the										18180
	the H in 24 the Fu	Medical	one)	Examiner: On the ba and mann		anu/or in			atri occuri	ed at the time,				
	With Void	Σ	29b. Signature and title of certifier	11/1			29c. Licens	se number	. 14		29d. Dat	e signed (Mon		
)			1/well	1 Cold			09.	157	8		_//	126/0	7	
	25		30. Name and address of person v		,		*		1	1	. 01-	700		
	8	•	Dr. Michael Cos	tello M.B	. 1564 gistrar's Signa	Upossi	mtown Pi	ke Fr	reder	ick, M) ZI/	/UZ		
	Sta	ıe	1404 2 (1 4001 /	March Sand	the state	Sales of the Sales							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** _P ^M 7:15 2007 /Medical CAROL JO-ANNE MAGNI NOV. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARY'S 38153 ETNA COURT MECHANICSVILLE Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 1 1 Months Davs Hours Director JAN. 17, 1943 WASHINGTON, DC 578-56-0658 64 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director ST. MARY'S MECHANICSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38153 ETNA COURT 20659 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1. Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 PARISH CHURCH BOOK KEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å THOMAS MAGNI JO-ANNE LAGANA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMARA L. SHOCKLEY/FRIEND 10904 DEMARR RD. WHITE PLAINS, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) NOV. 26, 20c. Location - City or Town, State 1 ☐ Burial 2 Incremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA METROPOLITAN CR. 2007 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Faneral Service Licensee 5635 WASHINGTON AVE. LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Aringe disease or condition resulting in death) /Medical Thacker STENDERS YEARS. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending ph IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. I certificate has been signed by the a rector, page 2 should be detached 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No ospital or Attending Physician; Thours after death. Ineral Director: After this certificate if filled in by the funeral director, pa 1☐ Yes 2☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Kells 8

ASSOCIATES

NOVEMBER 26, 2007

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HOLLYW DOD

MID

Gill

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.

MIMNDER

31. Date filed (Month Pay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 15, 2007 11:50_A м **Physician** Carrie Hare Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayside Care Center Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🖾 F 251-03-0505 92 Director November 6, 1915 | South Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified 1 ☐ Yes 2 ☑ No Director Lexington Park Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 21437 Morris Drive or items 23a 20653 Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Waitress 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 Is marked o any injury or other traumatic eve Wallace Hare Addie Rholetter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Elaine Moore / Daughter 21519 Morris Drive Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State November 21. Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Joy Chapel Cemetery 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line Leonardtown, MD 206 Approximate Interval Betweer Onset And Deatl pardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.0. by the a 9 🗆 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has rector, page 2 autopsy performed' 2 🐼 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient uneral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 D Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier

29b. Signature and title

30. Name and address

of certifier

19

2007

24035 Three Notch Road

31. Date filed (Month, Day, Year)

Medical

State

Registrar

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

Hollywood, MD

🐯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

James P. Jarboe, M.D.

29d. Date signed (Month, Day, Year)

	Please Type or Print in B	Black Indelible Ink.	Ensure All Copies	s Are Legible.
	1- State of Maryland	d / Department of H Certificate of I	lealth and Mental Hy Death	/giene 2007 3837
Physician /Medical	1. Decedent's Name (First, Middle, Last) Mary Alice McWill	liams	2. Date of D Month Noven	eath 3. Time of Death
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. In the second security Number 1 and 1 an	Leonar	If Under 24 Hrs. 8. Date of Bi Hours Min. (Month, D	St. Mary's irth (ay, Year) 9. Birthplace (State or Foreign Country)
As other	Usual Residence of Decedent	y, Town or Location	July 27	10d. Inside City Limits
a-f shorified at	Maryland St. Mary's		ements	1 ☐ Yes 2 ☑ No
with the	10e. Street and Number 23409 Colton's Point Road	10f. Zip Code	.0624	10g. Citizen of What Country? USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I file m Z7 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		ispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.)	
ed within 72 houygiene.	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of working	16b. Kind of Business/Industry
d withir giene.	Elementary/Secondary (0-12) College (1-4or 5+)	Homemake		Own Home
be file and and and and and and and and and and	17. Father's Name (First, Middle, Last) Charles Henry Beitzell		18. Mother's Name (First, Middle	
should and Men amarke umartic	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street		inia Cheseldine ber, City or Town, State, Zip Code)
and 2 lealth a m 27 is her trai	William Patrick McWilliams / Son	210 Charles Stree		,
Pages 1 thent of H tant; if ite	1⊠Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Sac	Place of Disposition (Name of emetery, crematory or other place ered Heart Cemetery	2007	20c. Location - City or Town, State Bushwood, Maryland
permit Depart Import any in	21. Signature of Funeral Service Licensee Chechael Sliven Hardine	22. Name and Addre Mattingley P.O. Box 2	ss of Facility 7-Gardiner Funeral I 270 Leonardtown, MI	Home, P.A. D 20650
Physician /Medical	23a. Part1. Enter the diseal e, or complications that cause if the density shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	Epsel	ig, such as cardiac or respiratory	Approximate Interval Between Onset and Death
executed nand ial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	udumonu uence of):		1 day
ificate be executed physician and as the burial-transit edical Examir	resulting in death) Last Due to (or as a consequence) d.	uence of):		
the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate has been signed by the attending physician and inpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit ledical Certification: To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	I death 3 ☐ Ectopic pregnancy	,	23d. Date of delivery Month Day Year
quires that n signed that had be detailed by Pl	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause give		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Physician: The law require this certificate has been signal director, page 2 should L	Demantia		perl	24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No
ysician: The secrificate director, pag	25. Was case referred to medical examiner? 1	ER/Outpatient 3 DOA Oth	26. Place of Death (Check only	,
iding Phy th. After this funeral d	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of lnjury 28c. Injury World	4 But Nursing Home 5 Li Hes	how injury occurred
To the Hospital or Attending I within 24 hours affer death. To the Funeral Director: Affer completely filled in by the funer. Medical Certification:	e G Could not be	ome, farm, street, factory, office	28f. Location City or To	(Street and Number or Rural Route Number, own, State)
o the Hospitalithin 24 hours of the Funeral ompletely fille	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	wledge, death occurred at the tir tion and/or investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time	e cause(s) and manner as stated. s, date and place, and due to the cause(s)
To the Complex	29b. Signature and title of certifier	29c. Licens	e number	29d. Date signed (Month, Day, Year)
BY.	30. Name and address of person who completed/cause of death (Item		P. Jarboe, M.D.	11 15-01
State Registrar	24035 Three Notch Road Follywood, MD 31. Date filed (Month, Day, Year) Registrar's Signal			

DHMH 17 Rev 1/2001

P.O. Division or Vital Records,

Box 68760.

within 2 the ပ

e Funeral 1

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1004806

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEVIN LEE STITELY M.D. 505 DUTCHMANS LANE, EASTON, MD 21601

29a. Certifier

Medical

State

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ROBERT NOVEMBER DAY 6, 2007 WAYNE MASON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, May 7, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 15 M 2□ F 578-48-0926 69 1938 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lay or other traumatic event, the Medical Ex miner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Frederick 1 ☐Yes 217 No MD Middletown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2624 Bennies Hill Rd. 21769 USA Funeral 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 0 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) arrined Forces? 1957-1XC Yes 2 No 1961 If Yes, Give Year or Dates: 1961 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) systems technician telephone co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Harry Mason Mabel Raines 19a. Informant's Name/Relationship (Type. Print) Mary Jo Mason (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 Is any Injury or other trau 2624 Bennies Hill Rd., Middletown, MD21769 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory 11/19/07 Smithsburg, MD 20a. Method of Disposition 1 Burial Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen. Donard ddr B. Thompson Funeral Home Mel P. O. Box 18, Middletown, MD 21769 Approximate Interval Between Onset and Death art1. Enter the disease, or complications that hock, or heart failure. List only one cause o caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedian Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** MICHAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (or as a consequence of) Examiner that initiated events resulting in death) Last OTO NOT Due to (or as a consequence of): physician at s the burial-t Physician/Medical attending p for use as SS IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ITYes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 No 1 ☐ Yes 1☐ Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 21 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Fo the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director;
completely filled in by the

State

Year) 2007 Registrar

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

6 Could not be determined

30. Name and address of person who completed ause of death (Item 3a) (Type, Print)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Edward Riuli 180 Thomas Johnson Dr., Frederick, MD 21702

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner related.

32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** November 18, 2007 MARGARET LOUISE **MYERS** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F 233-72-4814 93 Director 21, 1913 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director MARYLAND WASHINGTON SHARPSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18734 NICK ROAD Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 9 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 CAREGIVER HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VERNIA TERRANCE HUTSON NETTIE MAE JAMISON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18734 NICK ROAD, SHARPSBURG, MARYLAND 21782 JEANIE M. MILLS/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify) 11/21/2007 | SHARPSBURG, MARYLAND MOUNTAIN VIEW CEM. 21. Si nuce Livensee 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death #ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical d. Date of delivery Month Year contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1∖□Yes 2 □ 1√0 2 NO Be Other (Specify)

Examiner sician and burial-transit the death certificate be executed Division or Vital Records, P.O. Box 68760. attending physician for use as the buria To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

hours after death

within 72

and Mental Hygie

es 1 and 2 should b of Health and Ments I Item 27 is marked r other traumatic e

permit. Pages Department of Important: If It any Injury or o

Baltimore, Maryland 21215-0036

Certification: To

Medical

29a, Certifier

IF FEMALE: 23b. Was decedent pregnant in the past 12 monds? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but hydrosulting in the underlying gause given in Part I.	23e. Did tobacco use contribute to the cause of death
	lind ness cal Massive adekopathy	24a. Was an autopsy performed? 24b. Were autopsy findings avai prior to completion of cause death?
25. Was case referred to medical examiner?	26. Place o	1 Yes 2
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

350 MICL ST. HAGERSTOWN, MD 21740 ERANGISCO LI ANDRADE 31. Date filed (Month, Day, Year)

State Registrar

11H-3

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Agim Mema 12, 2007 8:02 p November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs. last birthday) 1X M 2 ☐ F 79 216-53-4197 Oct. 1928 Albania 1, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 10861 Lockwood Drive Albania Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hedije Bakalli Abdulla Mema 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10861 Lockwood Drive, Silver Spring, MD 20901 <u>Ginlieta Mema/ Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 15, Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. Como 500 University Blvd, W. Silver Spring. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 X No

Physician /Medical Examiner the death certificate be executed

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

"naturai", or items 23a or 28a-f shovedicai Examiner must be notified at

the Medicai

Director

Funeral

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Completed

Be

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filed within 72 hours after death

Pages 1 and 2 should be filed an nent of Health and Mental Hygisint: If item 27 is marked other

permit. Pages Department of I Important: If its any Injury or o

Maryland 21215-0036

Baltimore,

Box 68760

P.O. |

Division or Vital Records,

Attending Physician:

physician and s the burial-trans as attending p use certificate has been signed by the a rector, page 2 should be detached funeral director, To the Hospita or Atteridity within 24 hours after death.

To the Funeral Director A completely filled in by the forms death.

25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🔼 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

110064588

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Ashish Tolia, MD

State Registrar 31. Date filed (Month, Day, Year) NOV 15 200



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Mary Lucille Parsons Messick November 13 2007 4 Ac. County of Death Ac	3. Wimb of Death
Second Security Number 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4	4:20 PM M
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed (Month, Date signed (Month), Date signed	ed.
D-0060515 11/13/27	ed. ne cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ed. ne cause(s)
Mahesha Thimmarayappa M.D. 614 Easternshore Dr. Salisbury MD 21804	ed. ne cause(s)
State Registrar 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	ed. ne cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 ovenin /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Maryland Medical If Under 1 Year | If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 1 F Director 042-62-9009 48 June 18, 1959 Connecticut Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Marylan Hygiene.
Other than "naturat", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 X Yes 2 No MD Dorchester Director Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Hayward Street Funeral 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 9 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Newell Akley P Lewis Knapp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecil G. Merritt husband 210 Hayward St., Cambridge, MD21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Salisbury Crematory 11/12/07 Salisbury, MD of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onselvand Death Immediate Cause (Final Physician dar /Medical resulting in death) Due to (or as a consequence of): Examiner uks Vin-small Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that linitiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit death certificate be executed na ta resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient ို 3 DOA 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 - Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

P.O. Box 68760, Division or Vital Records,

> State Registrar

31. Date filed (Month, Day, Year)

Laidi

29b. Signature and title of certifier

NOV 13 **20**07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

AU4176435Z18194

29d. Date signed (Month. Dav. Year)

2001

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/Medical **Examiner Funeral** Director filed within 72 hours after death with the Maryland ns 23a or 28a-f shor must be notified at "naturai", or Medical permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Physician /Medical **Examiner**

Director 21078 2216 Apollo Terrace Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2x Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker 17. Father's Name (First, Middle, Last) Frederick Wiemert 19a. Informant's Name/Relationship (Type. Print) Nelson E. Noble (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 10/22/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Immediate Cause (Final disease or condition resulting in death) oronan Due to (or as a consequence of): Sequentially list conditions, if any leading to in modific cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No ate has been signed by the a page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed 25. Was case referred to medical examiner? B 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a (Check only 29b. Signature and title of certifier 29c. License number livinan D 32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kammidun State

Day 18, Jennie Mary Noble October 2007 8:54 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2216 Apollo Terrace Havre de Grace Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗗 F 214-12-1579 90 March 28. Connecticut Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Personal Residence 18. Mother's Name (First, Middle, Maiden Surname) Florence Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Apollo Terrace, Havre de Grace, Maryland 21078 20c. Location - City or Town, State West Chester, Pennsylvania Lee A. Patterson & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21903-0766 Approximate Interval Between Onset and Death Disease 10 yrs 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1☐ Yes 25 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 10/19/0 MITTAM MS 1106 Revolution St Haure De Grave MS 21078 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 2 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November Day 2, 2007 7:30 A M **Physician** Μ. Newman Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Set | Part | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | Set | S 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Barrymore, MD 1 ☐ M 2 □ XF 101 578-20-4743 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" — any injury or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X1Yes 2□No Rockville Funeral Director MD Montgomery 10g, Citizen of What Country? 10f Zin Code 10e, Street and Number United States 20852 6105 Montrose Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify. Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Bessie ပ Harry Morgenstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Gode) 11006 Veirs Mill Road Suite L15 PMB 363 MD 20902 19a. Informant's Name/Relationship (Type. Print) Gary M. Newman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Mem.
Gårdens 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ARemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2007 Falls Church, VA 21. Signature of Funeral-Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville MD 20852 Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** manition disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 No or Attending Physician: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[] No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manur of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Injury 1 Tyes 2 TNo death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

32 Registrar's Signature

0(2

07-08600 Allison M. Purvis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

son M. Purvis		- For State	ate of Maryla	and / Depa <i>Cer</i>	rtment of tificate of	Health and Death	l Mental		g. No. 2(007 3838	
Physician		egistrar I. Decedent's Name (First, Midd	le,Last)					Date of Death Month		3. Time of Death 0737 hrs	
edical Examin	er	Alyson Michelle Purvis November 5, 2007									
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		Skinners Turn Road a			himb days	If Under 1 Year	If I Index 2	4Hrs 8 Date of Birt	th (MM/DD/YYYY) 9.	Birthplace (State or	
Funeral	1	5. Social Security Number	6. Sex	7. Age (In yrs. Ia		Months Days		A Alice	.6, 1990 For	reign Washington,	
Director	Ĺ	219-29-6921	1 M 2 X F	17	Yrs.			1001. 1	0, 1990		
8-	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on				10d. Inside City Limits	
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Maryland 28a-f show any d at once.	핡	MD Calve 10e. Street and Number	ert County	7	Chesape	ake Beac 10f. Zip Code	<u>h</u>	1	0g. Citizen of What C	Country?	
ith the Maryland 23a or 28a-f sho notified at once.	Director		d Count			20732		i	U.S.A.		
ith th		2442 Woodland	12. Was De	ecedent Ever in U	.S. 13. Wa	s Decedent of His	panic Origin	? (Specify Yes or No	14. Race - Ar White, et	merican Indian, Black,	
ath w items	uneral	1 X Never Married 2 N	Married Armed F	orces?	If Y	es, specify Cubar	n, Mexican, Pi	uerto Rican, etc.)		1	
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ours a atura camin	g p	15. Decedent's Education (Sp.			16a. Deceder during m	nt's Usual Occupa lost of working life	tion (Give kin . DO NOT us	d of work done e retired)	16b. Kind of Busine	ess/industry	
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ogy vithin ene.	Completed	12			St	udent	18.Mother's	Name (First, Middle,	High Sc. Maiden Surname)	1001	
215-0036 be filed within mtal Hygiene. rked other tha		17. Father's Name (First, Middle Robert B.						san Jones			
21215-0036 suld be filed within 72 hours after Mental Hygiene. marked other than "natural"; ie event, the Medical Examiner	To Be	19a. Informant's Name/Relation			19b. Mailin	g Address (Stre	et and Numbe	er or Rural Route Nu	mber, City or Town, S	State, Zip Code)	
sho and and natis		Robert B. Pur		her)	2442	Woodland	1 Ct.,	Chesapeak	ke Beach,	MD 20732	
ore, MC es 1 and 2 st of Health an If item 27 her trauma		20a. Method of Disposition			Place of Dispo	sition (Name of ce ther placeGaro	emetery,	Nov. 15.	20c. Location - Ci	ity or Town, State	
F % % = 8		1 X Burial 2 Crematic		from State Ch		e High.		2007	Port Re	public, MD	
Baltimo permit. Page Department of Important: injury or otl		4 Donation 5 Other 21. Signature of the signature of the	cellinsee		22.	Name and Addres	s of Facility S	3125 South	nern Maryl	and Blvd.	
Balti permit. Departu Import injury	-	Michael Williams 23a. Part I. Enter the disease,	ee		L€	e Funera	al Home	e Calvert,	P.A. Ow	ings, MD 20736	
Physician		23a. Part I. Enter the disease, failure. List only one caus	of complications that se on each line.	t caused the deat	h. Do not enter	the mode of dying	, such as car	diac or respiratory a	rrest, shock, or heart	Between Onset and Death	
aminer		Immediate Cause (Final disease a. Head Injuries									
ammer		or condition resulting in death) Due to (or as a consequence of):									
	ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as	s a consequence	of):						
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b isit	Examine	events resulting in death) Last Due to (or as a consequence of):									
), be executed sician and urial - transit	dical	UNPENDED	d	D	10/5/07	rm / 20	ME -9	7/. 12/17/0	7 / TT		
O, e be e ysiciai burial	ledi		#I.pe	erME_g8/4.	12/5/0/_ egnancy	TT/ Zoa pe	er ME go	874, 12/ <u>17/0</u>	23d. Date of de	elivery	
Box 68760, e death certificate bette attending plysiced for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	n the 1 Liv	e birth	2 🔲 F	etal death 3	Ectopic	pregnancy	Month	Day Year	
X 6 th cer ttendi	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 7 Yes 2 No 9 Unknown 9 Unknown								()	
rds, P.O. Box	hys	Part II. Other significant con	9011		t resulting in the	underlying cause	e given in Par	t I. 23e. Did	tobacco use contrib	ute to the cause of death?	
P.O. es that the igned by be detac	by	Part II. Other significant con	on on one	9 10 00000				1 1	res 2 ✔ No 3	Probably 4 Unknown	
S, F quires en sig	Completed							24a. W		ere autopsy findings available for to completion of cause of	
Corc lav re ha be 2 hor	aldu			ре	autopsy performed? death? ✓ Yes 2 No 1 ✓ Yes 2 No						
tal Reccitan: The lay	Son					26 Pla	oce of Death /		s Z NO	V 163 2 110	
Vital Rec ysician: The l his certificate l	Be										
F VI Physic or this	ပို	1 Yes 2 No	28a. D	? 28d. Descrit	28d. Describe how injury occurred						
n of \ding Phy. h	S 1 Natural 5 Posters Nover Provided in the Communication Nover P										
ivisior or Attend after death Director:	cati	2 🗸 Accident Ir	nvestigation NOV	. 5,2007 _ Place of Injury - A	t home, farm, st	reet, factory, offic	e building, et	c. 28f. Locatio	n (Street and Numbe	er or Rural Route Number, City	
Division of Vital Records, pital a Records, ours after death. reral Director: After this certificate harbeen silled in by the funeral director, page 2 mould the control of the funeral director, page 2 mould the control of the funeral director, page 2 mould the control of the funeral director, page 2 mould the funeral director, page 2 mould the funeral director, page 2 mould the funeral director, page 2 mould the funeral director, page 2 mould the funeral director, page 2 mould the funeral director, page 2 mould the funeral director, page 2 mould the funeral director of the f		3 Suicide 6 0	Could not be	cify) Major Ro				Skinners T	n, State) urn Road and Rou	ute 4, Owings, MD	
Hospit Hospit Hour	ြင္မ	29a. Certifier 1 Certifyin					, date and pla	ace, and due to the c	ause(s) and manner	as stated.	
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	edical	(Check only one) 2 Medical	Examiner: On the ba	isis of examinatio	n and/or investi	gation, in my opin	ion, death oc	curred at the time, d	ate and place, and do		
5 ½ ½ Ç	N S	29b. Signature and title of ce		0		i	ense number		1	ed (Month, Day, Year)	
		1 oishe	2 Jes	2 her)	О.	C.M.E.		November	0, 2007	
	1	30. Name and address of per	rson who completed				. D.W.	MD 04004			
lew 3	ĺ	Tasha Greenberg		t Medical Exa		11 Penn Stree	et, Baitimo	ore, MD 21201			
5		31. Date filed (MoNOV.Y	1º4 2007 32	2. Føgistrar's Sigr	nature	Carle 0					
Regis				A THE WAY THE WAY IN	- A - A - A - A - A - A - A - A - A - A	The state of the s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State amend item 28a per ME g877 03/20/08 amb Certificate of Death

Reg. No. Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 200 Kyan Ku VV15 /Medical 4c. County of Death 4a. Facility name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ka Himore University 01 Tarylan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Year 1**X** M 2□ F Yrs 1993 Washington, DC Director 219-39-1726 14 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director Calvert County Chesapeake Beach 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20732 2442 Woodland Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event. the Me College (1-4or 5+) Elementary/Secondary (0-12) High School 9 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert B. Purvis Susan Jones ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2442 Woodland Court, Chesapeake Beach, MD 20732 Robert B. Purvis (Father) 20b. Place of Disposition (Name of cemetery, crematory or data padens Nov. Date 15, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Port Republic, MD Chesapeake High. Mem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fu 8125 Southern Maryland Blvd., Owings. MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) A Miratory a /Medical Due to (or as a consequence of): Examiner no Sequentially fist conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ma and CERTIFICATION APPROVED BY ME Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 ☐ Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 TYes 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2 **¼** No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day Year) 7:08 AM 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑No 2 Accident MVA tassenger 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number of Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: Notice notice after death.

To the Funeral Director: A

State Registrar

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Eccrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

E Hz

determined

18234

Skinnere Turn Pd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennett DOWALD R

and manner stated.

Registra

Signature

Greene

4 Homicide

29a. Certifier

Medical

			For	ate of Maryland / Department	artment of Health a					
4	Physicia	an	1 - State Registrar 1. Decedent's Name (First, Middle, Last) John David Porter		rtificate of Death	2. Date of Deat Month	Day Year	3. Time of Death 9		
/Med Exami			4a. Facility Name (If not institution, give street Calvert Memorial Hos	4b. City, Town, or Location of Prince Freder		per 11, 2007 2:37 P.M. 4c. County of Death Calvert				
Ì	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday)			Year) 9. Birt	hplace (State or Foreign untry) prida		
215-0036	he Maryland 8a-f show otified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Calvert	10c. City, Town or Lo Solomons	5		On Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	h with ti		10e. Street and Number 510 Aldersgate Court	#514	10f. Zip Code 20688		og. Citizen of What Co United Sta			
	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		1 □ Never Married 2 □ Married 1 [☑Yes 2 □ No	Was Decedent of Hispanic Origi if Yes, specify Cuban, Mexican, 1 ☐ Yes 2√√ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify:			
	ithin 72 ho ne. nan "natur nadical l		15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) (Give bllege (1-4or 5+)	dent's Usual Occupation a kind of work done during most DO NOT use retired)	of working	16b. Kind of Business/			
d 21	filed within 7 Hygiene. other than "r ent, the Med		17. Father's Name (First, Middle, Last)	4 Sale	esman 18. Mother	s Name (First, Middle, M	Steel Indu Maiden Surname)	stry		
<u>lan</u>	ould be a Mental arked o		John David Porter		Edna	May Halste	d			
re, Mar مراضط	es 1 and 2 should b of Health and Ment fitem 27 is marked ir other traumatic e		19a. Informant's Name/Relationship (Type. Pri Bruce A. Porter (Son		ing Address (Street and Number 58 Santa Rosa R					
	Pages 1, nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	osition (Name of smatory or other place) Litan Crematory		20c. Location - City or Alexandria	Town, State , Virginia		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee		 Name and Address of Facility P. O. Box 600, 	Lusby, Mar				
×	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition	is that caused the death. Do not enuse on each line.	iter the mode of dying, such as o	ardiac or respiratory arr	est,	Approximate Interval Between Onset and Death		
Examin	/Medical Examiner			Due to (or as a consequence of): Small yould	obstruction	bsprution				
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injusted events c.							
8760,	ficate be executed g physician and is the burial-transit	g	resulting in death) Last	Due to (or as a consequence of):	0.0.1					
O. Box 68 he death certificat	The law requires that the death certificate te has been signed by the attending physoge 2 should be detached for use as the	tion: To Be Completed by Physician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
ds, P.(w requires that been signed by should be deta		Part II. Other significant conditions contribut	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
			Amal fibrill Renal insufficie	ation		autops perfor	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Vita	vysician: This certificate director, pag		25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al:	Other:	ace of Death <i>(Check only one)</i> Nursing Home 5 ☐ Residence 6 ☐ Other <i>(Specify)</i>				
Division or	or Attending Physiter death. Director: After this in by the funeral di		I Les ZM No	a. Date of Injury (Month, Day Year) 2 □ ER/Outpatie 28b. Time injury	nt 3 DOA 4 Nur	cify)				
Divisi	al or Attendate after death	Certification:	a Could not be	e. Place of injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Si City or Town	reet and Number or R. n, State)	ural Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
}	Mithin To the Comp	Me	29b. Signature and title of certifier	29c. License number 0 6 0 3 9 0	2	9d. Date signed (Mont				
Ó	4+1		30. Name and address of person who completed AOEEB JABER	ted cause of death (Item 23a) (Type	Print) O. PRINCE	FREDERICK	, mo 2	0678		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 14	32. Registrary Signature	Specific					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** PETTIT THERESA 1210 PM 2007 11 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗙 F 50 Yrs. District of Columbia 217-78-1733 Director July 30, 1957 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any jiry or other traumatic event, the Medical Examiner must he provided once. 10c. City, Town or Location 10d. Inside City Limits 10a. State tx☐Yes 2☐No St. Mary's Leonardtown Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43721 Redmond Road 20650 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Thrift Store Elementary/Secondary (0-12) College (1-4or 5+) Stock Clerk 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Horace Lamar Pettit Marian Cecelia Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cecelia Price / Sister 43721 Redmond Rd. Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State November Charles Memorial Gardens Leonardtown, Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, MD 200 tardine Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CERESCUAR Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MYOCAMINA INFANCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate has rector, page 2 C ENE BRON 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD DB096 11-16-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSPITAL LÉONARD TOWN MANYS 57 676L 31. Date filed (Month, Day, Year) State 19 2007

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

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State Registrar

DHMH 17 Rev 1/2001

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Comos tascahous MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

31. Date filed (Month, Day, Year)

McCornack

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 38393 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 14, 2007 **Physician** Maria Rosa Palomo 11:08 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 21, 1 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 111-46-0640 1920 Costa Rica Director 87 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10h County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be n 9425 Curran Road 20901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status "natural", or iten Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2□ No þ Specify: 3 Widowed 4 Divorced Costa Rican White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Lry or other traumatic event, the M Residential Homes 8 Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Palomo Maria Cascante 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Schloner/ Daughter 12219 Walnut Creek Court, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itea November 1 StBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 19, 2007 Rockville, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, License 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Imme iats Came Fnal disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Alzheimer's disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed stcian and burial-tran Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Osteoporosis 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an page 2 autopsy performed? certificate 3€ No 1□ Yes 2⊋No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 ☐ Pending investigation 1 XNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0045459 November 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lucy M. Carrea, M.D., 344 University Blvd. West, #215, Silver Spring, MD 20901 31. Date filed (Month, Day, Year) 32 egistrar's Signature NOV 15 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Month Physician Robert S. Rizzo Nov. 14, 8:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 23631 Ridge Road Germantown Montgomery 9. Birthplace (State or Foreign Country)
New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 4, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days ^{Year)} 1927 Hours 1 **X**M 2 □ F 80 210-18-8131 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2 🔀 No Director Maryland | Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 23631 Ridge Road 20876 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑X/es 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Computer Center 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) National Institutes of Health 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ε. Gactano Rizzo Dorothy M. Newton ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grace H. Rizzo - Wife 23631 Ridge Road, Germantown, Maryland 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dopation 5 NOther (Specify) Entombment Mt. Olivet Mausoleum 11/20/07 Frederick, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Fur
26401 Ridge Road, Damascus, 21. Signature of Runeral Service Lipensee Funeral Home Koveri 20872 X. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GALLBLADDER CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autopsy
performed

1 Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury hours after death.

uneral Director: Af
ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Dires 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fun

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 15, 2007 016619 w MD 30. Name and Press of person who completed cause of death (Item 23a) (Type, Print)

1. VEDLADA - SOARES 9940 FRANKUN SONARE DR. BALTINORE, ND 21236 32. registrar's Signature 31. Date filed (Month, Day, Year) State 2007 MOX 1 9

Registrar

within 24 hours at To the Funeral D

DH-5 State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAGERSTOWN, MARYLAND 21740 VASANT DATTA, 340 MILL STREET.

NOV 2 1 2007

com sos

Registrar

(Check only

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

7108) a

29d. Date signed (Month, Day, Year)

NOV 19 2007

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			1 - For State Registra AMEND#1+23 openM	State of Maryland				nd Mental	Hygien Reg. N	211111	38396
	Dhysis	ion	1. Decedent's Name (First, Middle, Last)	Bernard Wesle	y Ritt	erpusc	h,/Jr	2. Date Mont		ayı Year	3. Time of Death
	Physici /Medi			SOYNOWO	KAI	erpisc	96		DV 13	2007	- 6.20 PM
	Examir	ner	4a. Facility Name (If not institution, give s		/		n, or Location of		4	c. County of Dea	
			Holycross Kehus		center	Burto	onsville		150	Montgo	
	Funeral Director		5. Social Security Number 6. Sex 215-34-1771 10	7. Age (Myrs. 170 70 70 70		Months Day			n Day Yea	1937 Ma	thplace (State or Foreign ountry) cryland
	fand ow		10a. State 10b. County	10c. City	, Town or Loc	cation			·		10d. Inside City Limits
	Many Heat	ţ	Md. Montgome	ry R	ockvil	1e					1 ☐ Yes 2 📉 No
	r 288	lrec	10e. Street and Number			10f. Zip Code	ө		10g. C	itizen of What C	ountry?
	th wit	alD	2002 Baltimore Ro	ad Apt.B21			20851		Un	ited Sta	ates
Maryland 2	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie markad other then "naturel", or items 23a or 28a-1 show or other traumatic event, the Modical Examinatious Leading at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	2. Was Decedent Ever in U.: Armed Forces? 1 ∰Yes 2 ☐ No 195 If Yes, Give Year or Dates: 195	5 - If	Vas Decedent of Yes, specify C	of Hispanic Origin Luban, Mexican, I No <i>Specify:</i>	n? (Specify Yes Puerto Rican, etc	or No-	14. Race - Ame Black, Whi Specify:	
	within 72 ho ane. then "natur be Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. D	ent's Usual Ockind of work do NOT use ret	ne during most d tired)	of working		Kind of Business	Andustry
	12 should be filed within " n and Mental Hygiene. r ie markad other then " " raumatic event, Ihe M. s.	To Be Co	17. Father's Name (First, Middle, Last) Bernard W. Ritter	pusch Sr.				s Name (First, M		n Sumame)	
	alth and I		19a. Informant's Name/Relationship (Ty) Helen Watkins (Sis						-	or Town, State,	
Baltimore,	permit. Pages 1 and 2 Department of Health of Important: If item 27 i eny injury or other tra <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	ition (Name of latory or other p Ltan Cr	olace) N	ov. 16, 2007		Location · City or	
Balti	permit. Pag Department Important: f eny injury o		21. Signature of Funeral Service License	Day			dress of Facility Deer Pa		Tunera	1 Home	MD 20877
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1	whysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, bacing to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ianda uf):					,	
	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes							23d. Date of de Month	livery Day Year
	quires that n signed b	by	ADRIC STENDS S RENAL DISUFFICIENCY 239. Did todac 24a. Was an autopsy performer.							acco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Onknown	
		Completed								24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				-	Death Check	only one)		
of	Physical this call direct	ည	1 105 212110	ospital: 1 Inpatient 2 E		3LI DOA				6 ☐Other (Spe	cify)
		on	27. Manno of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In			ribe how inju	ury occurred	
Division	the the	Certification:	2 Accident investigation 3 Suicide determined M 1 Yes 2 No 2 No M 1 Yes 2 No 3 Suicide determined M 1 Yes 2 No 286. Place of Injury - At home, farm, street, factory, office 287. Location (Street and Number or Rural Roll City or Town, State)							ural Route Number,	
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Diractor: After completely filled in by the funerel or the funerel	edical Ce									
	o the	Med	29b. Signature and title of certifier	and market stated.		29c. Lice	ense number		29d. D	ate signed (Mont	h, Day, Year)
			Manua.	0000		n o	28595		11	luda 2	
5	+1		30. Name and address of person who con	poleted cause of death (Item	23a) (Type P		x01 11		- 1	14107	
			TASNEEM LAKE	tani, 2835		Λ	IE, SUI	TE 203	BAC	m m D 2	1209
	Sta Registr		31. Date filed (Month, Day, Year) NOV 15 200	32. Agistrar's Signati		make 0	/				

State

Registrar

29b. Signature and title of certifier

PREET

31. Date filed (Month, Day, Year)

Freet Bagi

BAGI

NOV 15 2007

29c. License number

22 S. GREENE STREET, BALTIMORE, MD. 21201

AU4176435818128

29d. Date signed (Month, Day, Year)

NOV. 12, 2007

and manner stated.

MD.

ngistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-09006 Ronald Robert Ra	affel	Please Ty	pe or Print in tate of Marylar	Black In	<mark>delib</mark> l	le Ink. Ens	sure All C and Ment	opies Are Leg al Hygiene	ible.	
	1 F	- For State		Cer	tificat	e of Death			g. No. 20	07 3839 (
Physicia Medical Examin	-	1. Decedent's Name (First, Mide RONALD	TATISTIC	R. Raffe	11			Month November	Day Year 21, 2007	1907 hrs
*		4a. Facility Name (if not instituti	ion, give street and num			4b. City, Tov Gaither	vn, or Location o sburg	f Death	4c. County of Dear Montgomery	th
Funeral		5. Social Security Number		'. Age (In yrs. la	ast birthd	ay) If Under Months	1 Year If Unde	Min	h(MM/DD/YYYY) 9. B Fore	irthplace (State or ign WASHINGTON ountry) DC
Director	-	215-72-5014 Usual Residence of Decedent	11K M 2 F	5(0	Yrs.		MAY 15	, 1957	ountry) DC
* any		10a. State 10b. County			Town or					10d. Inside City Limits 1 X Yes 2 No
rryland Sa-f sho	Director	MD MONT	GOMERY	GERM	ANTO	MN 10f. Zip C	ode	1	0g. Citizen of What Co	untry?
h the Ma 3a or 24		19313 RUNNING			- C	2087			SA	erican Indian, Black,
Baltimore, MD 21215-0036 Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2	Armod Eo	edent Ever in U rces? 2 x No	.S. 1			gin? (Specify Yes or No , Puerto Rican, etc.)	White, etc.	
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0036 within giene.	Completed	17. Father's Name (First, Midd	le Last)		MAR	KETING M		r's Name (First, Middle,	RETAIL Maiden Surname)	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	a	BERNARD RAFFE	L					S ROSOFF mber or Rural Route Nur	when City or Town Str	eto Zin Code)
MD 21 nd 2 should alth and Me :m 27 is ma	٤	19a. Informant's Name/Relation JANICE RAFFEL						E, POTOMAC,	MARYLAND	20854
re, N s 1 and 3 f Health If item 5		20a. Method of Disposition 1 X Burial 2 Cremat	ion 3 Removal fro	m State	cremator	Disposition (Name ry or other place)		Date	20c. Location - City	
Baltimore, bernit. Pages I an Department of Hes Important: If ite		4 Donation 5 Other 2) Signature of Funeral Servi	Specify:	MT	. LE	BANON CE		11/25/2007		
Bal permi Depar Impo injur	1 ((HARM				11170 00	CVUTTIE	BERG MEMORI PIKE, ROCK	VIII.E. MAR	YLAND 20852
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aminer		Immediate Cause (Final disea or condition resulting in death								
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Ox 68760, and certificate be ex attending physician for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant i	23c. If yes,	outcome of pre	gnancy	erME,g874.		pic pregnancy	23d. Date of deli Month	very Day Year
Box 68760, s death certificate be the attending physic of for use as the bur	ician	past 12 months?	4 Pregr	ant at time of o	death 5	Fetal death Other (Spec		ore programey		
the de		Part II. Other significant cor	9 Olikii		resulting	in the underlying	cause given in I			e to the cause of death?
S, P.O. Lires that the signed by deed detacl	ed by		·					1Y [24a, Wa		Probably 4 V Unknown e autopsy findings available
Records, The law require ficate has been s'	Completed							aut	opsy prior formed? deat 2 ✓ No 1	to completion of cause of h? Yes 2 No
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(054 MMH ion of Vital Itending Physician: Icath. tor: After this certif the funeral director,	To Be	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2			OA Other 4	Nursing Home 5 28d. Describ	Residence 6 C	Other: Scene
On of on of and ing Plant. On or: After the funeral	Certification:	1 Natural 5 F	Pending Fnd 1	h, Day,Year) . 1/21/200	7 Fnd	7:00 pm	1 Yes 2			
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Division of Division of Division of Division Attending Ph within 24 hours after death. To the Funeral Director. After completely filled in by the funeral		29a. Certifier	o Physician: To the he	st of my knowle	edge, dea	ath occurred at the	time, date and	place, and due to the ca	use(s) and manner as	stated.
To the within To the complet	Medical	one) 2 Medical 29b. Signature and title of ce	Examiner:On the basis and manner	of examination stated.	and/or ii		opinion, death	er		(Month, Day, Year)
	2	29b. Signature and the or of	W. K.	/ m.	den a d		O.C.M.E.	OCME	November 22	2, 2007
		30. Name and address of per		ge of death (It ant Medica		iner 111 Pe	enn Street. F	Baltimore, MD 212	01	
	tate	Theodore M. King,	early 2007 32.	egistrar's Sign		A-16-		,		
Regis		1101 4	. 2001	BLAR.	15	MANUAL S	· · · · · · · · · · · · · · · · · · ·			

amend 20a-22 per hosp. g873 11/30/07 KBH
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of Marylan	d / Department of He		ntal Hygiene	2007 38399
			Registrar 1. Decedent's Name (First, Middle, Last	*1	Certificate of D		Reg. No.	
	Physic	an	- MANUEL	A. Se		2	Month Day	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give	12.000	45 Cit. T A.	(B)	01-21	1001 700 11 M
1	Examir	ner	Par MAR (3)	of als thes	4b. City, Town of L	oulp Blu	46.	Winty of Death
	Company		Social Security Number 6. Se	7-2	last birthday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	Birthplace (State or Foreign
	Funeral Director			M 2□F	Yrs. Months Days	Hours Min	Date of Birth (Month, Day, Year)	1 Country Collection
			Usual Residence of Decedent			7 200 0	, , , , , , ,	777777777
	ylan		10a. State 10b. County	10c. City	y, Town or Location			10d. Inside City-Limits
	a-f	Stor	MD Panley	JEBEJES	KANDOUL	Kens		1 Pes 2 No
	or 28	Director	10e. Street and Number	01/72 1	10f. Zip Code	3 7	10g. Citiz	ten of What Country?
	th wi	is I	2406 001	4/11/SEAT	00	20/05		4.5.11
	ems .	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hisp if Yes, specify Cuban,	anic Origin? (Specif	y Yes or No-	Race - American Indian, Black, White, etc
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1□ Yes 2₽No			Specify: SIACK
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. viter than "natural", or Items 23a or 28a-f ehow int, the Medical Examinat must be incitified at	q p	3 Widowed 4 Divorced	Year or Dates:				
-5	n 72	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usual Occupati (Give kind of work done dur life. DO NOT use retired)		16b. Kir	d of Business/Industry
12	withi 6ne. then	щć	Elementary/Secondary (0-12)	College (1-4or 5+)	Me. DONOTUSE TENTED	LAfor	7	ONI- LAFAM
	filed Hygir Sthar		17. Father's Name (First, Middle, Last)	1	1	8. Mother's Name (F	First, Middle, Maiden	Sumame)
an	d be ental ked c	То Ве		05C		tared	DAWN	Wilsan
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	and 2 ealth a n 27 is		LALEN. DAWN	Fuse	240/ AC	947514	TEUN	ANDUVILMO
Baltimore,	t Health Item 27 other tre	1	20a. Method of Disposition	20b. P	lace of Disposition (Name of emetery, crematory or other place)	Date	20c. Los	cation - City or Town, State
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Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3 ☐ Ectopic pregnancy		2	3d. Date of delivery Month Day Year
o.	at the de by the c tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5 Other (specify)			,
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Ś	es be		Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlying cause given	in Part I	23e Did tobacco us	se contribute to the cause of death?
ਰ	sig d b	d by	Part II. Other significant conditions con	ntnbuting to death but not resu	ulting in the underlying cause given	in Part I.		e contribute to the cause of death?
ord	v require been sig should b	eted by	Part II. Other significant conditions con	ntributing to death but not resu	liting in the underlying cause given	in Part I.	1 □ Yes 2	Probably 4 Unknown
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	The taw requitelete has been spage 2 should	Completed		ntnbuting to death but not resu	ilting in the underlying cause given	in Part I.	1 ☐ Yes 2 2 24a. Was an	24b. Were autopsy findings available
	9 4	Be Completed	25. Was case referred to medical examiner?	Ansnital:	2 Other	26. Place of Death (C	1 Yes 2 2 24a. Was an autopsy performed? 1 Yes 2 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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Division of Vital	or Attending Physician: ifter death. Director: After this certifice in by the funeral director. p	edical Certification; To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examined) 29b. Signature and title of certifier 30. Name and address of person who could be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my knowner: On the basis of examinat and manner stated.	EP/Outpatient 3 DOA Other: 28b. Time of North Properties of North	26. Place of Death (C 4 Nursing Home t 28d is 2 No 28f date and place, and ion, death occurred	24a. Was an autopsy performed? 1 Yes 2 No Check only one) 5 Residence 6 1. Describe how injury Location (Street and City or Town, State) due to the cause(s) at the time, date and	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other (Specify) occurred Number or Rural Route Number, and manner as stated. place, and due to the cause(s)

P.O. Box 68760, Division or Vital Records,

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Registrar

29b. Signature and title of certifier

NOV 3

6/4 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year!

0 2007

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

UCKW

Physician /Medical **Examiner** law requires that the death certificate be executed

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

nd 2 should be filed vallth and Mental Hygie 27 is marked other I raumatic event, the

nt of Health a : If item 27 is permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr. once.

Pages 1 and 2 should

filed within 72 hours after death

3altimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

physician and is the burial-trans attending physic for use as the b ed by the a detached f been signed by a should be detact page 2 has funeral director, After

Be

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Certification:

Medical

1 ☐ Yes 2 No

27, Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

autopsy performed? 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11-20-0

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

determined

28130 Three Notch Road, Mechanicsville, MD John W. Roache, M.D. 31. Date filed (Month, Day, Year NOV

State Registrar

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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

death.

filled in by the

	08894 hy Shumake	ſ		e or Print in B te of Maryland								
	,		1- For State Registrar	ic of Marylana	Certifica			a Wichtai II		eg. No. 20	07 3840	
Ţ	Physici	an/	Decedent's Name (First, Middle,	Last)					2. Date of Dear	th	3. Time of Death	
IVIE To	dical Exami	ner	Kathy Shumake: 4a. Facility Name (if not institution,		·\	1.	b. City, Town, or	Location of Death	Month November	r 17, 2007 4c. County of E	0822 hrs	
ě.,			28059 Pastor Ct.	give outed and named	,		Mechanicsv			St. Mary's		
	Funeral		Social Security Number 6	. Sex 7. A	ge (In yrs. last birt	hday)	If Under 1 Year		_	th(MM/DD/YYYY) 9	Birthplace (State or	
	Director			1 M 2X F	44	Yrs	Months Days	Hours Min	March	7, 1963	oreign Washington, Country)	
	any		Usual Residence of Decedent 10a. State 10b. County	.,	10c. City, Town	or Locati	on				10d. Inside City Limits	
	* .	_	Maryland St. 1	Mary's	Mech	ani	csville				1 Yes 2 No	
	hours after death with the Maryland natural", or items 23a or 28a-f show Examiner, must be notified at once.	Director	10e. Street and Number 28059 Pastor C	t.			10f. Zip Code 20 6	659	1	0g. Citizen of What USA	Country?	
5	h with ems 23	eral	11. Marital Status	12. Was Deceder			s Decedent of His			14. Race - A White, e	merican Indian, Black,	
\equiv	er deat , or ite	Fun	1 Never Married 2 X Marr 3 Widowed 4 Divon		X No		Yes 2 X No		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Specify:	White	
	urs aft tural" amine	d by	15. Decedent's Education (Specif	or Dates:		Deceden	t's Usual Occupat	ion (Give kind of		16b. Kind of Busin	ess/Industry	
	5 72 ho in "na cal Ex	lete	Elementary/Secondary (0-12)	College (1-4 or	5+)	-	ost of working life ement Of:		ired)	Beltway	Ti+10	
	within siene.	Completed by Funeral	12 17. Father's Name (First, Middle, L.		36	: L L I			n (Finna Adiabalo I	Maiden Surname)	11t1e	
	215- be filed ital Hyg ked ott	Be C	Frank E. Gilge:						Duncan	waiden Sumaine)		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importants. If item 27 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner.</u>	2	19a. Informant's Name/Relationship Kevin A. Shuma	p (Type, Print) ker/Husban d	1 28	. Mailing	Pastor	t and Number or Ct., Mec	Rural Route Nur hanicsv :	nber, City or Town,	State, Zip Code) 20659	
	re, N I and FHealth Fitem		20a. Method of Disposition 1 X Burial 2 Cremation	2 Democrat from C	cremati	orv or atl	ition (Name of cer	N	ov. 21,	20c. Location - Ci	ty or Town, State	
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Fyneral Service Licensee 22. Name and Address of FacilityBrin:					2007	Helen,	MD					
	Salti ermit. Separti mport		21. Signature of Funeral Service Li								.н., Р.А.,	
	Physician	\dashv	23a. Part I. Enter the disease, or co	omplications that cause	Mco8/7 d the death. Do no						Ha11, MD 20622 Approximate Interval	
	/Medical	1	failure. List only one cause or Immediate Cause (Final disease	a. Methadone a	and exveede	ne ii	ntoxicatio	n complica	ted by ac	ute broncho	Between Onset and Dne monia Death	
	caminer		or condition resulting in death)	Due to (or as a cons				1				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of):							
		Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):							
	ecuted and transit			d								
	Records, P.O. Box 68760, The law requires that the death certificate be execut cate has been signed by the attending physician and page 2 should be detached for use as the burial - tran	Physician/Medical	X UNPENDED	#23a 27. 2	28a-f, perl	Æ,g8	74, 12/13/0	07 TT				
	Box 68760 re death certificate b the attending physi	M/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnancy 2	Fe	tal death 3	Ectopic pregn	ancy	23d. Date of de Month	Day Year	
	OX 6 sath cer attend	sici	1 Yes 2 No 9 V Unknown		t time of death	ot Ot	her (Specify)					
	the de charter by the	Phy	Part II. Other significant condition	9 Ulkilowii	th but not resulting	g in the u	inderlying cause g	given in Part I.	23e. Did to	obacco use contribu	te to the cause of death?	
	P,C	d by		-					1 Ye	s 2 🗸 No 3	Probably 4 Unknown	
	rds, requir been s	Completed		-					24a. Was		re autopsy findings available or to completion of cause of	
	eco he law ite has	duc							perfo	rmed? dea	ith? Yes 2 No	
	an: T	Be	25. Was case referred to medical	L			26.Place	of Death (Check				
examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other: Scene												
The second secon												
	SiOI Attency r death	cati	2 Accident Investi	gation FNG 11/	.,	1 8:0	Jan		unk	Street and Number	or Rural Route Number, City	
	Division of Vital Records, P.O, tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 X Could determ	not be	njury - At home, fa Found at re			randing, etc.			chanicsville, MD	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra		29a. Certifier 1 Certifying Phy	sician: To the best of r	ny knowledge, dea	ath occur	red at the time, da	ate and place, an	d due to the caus	se(s) and manner as	s stated.	
	To the within 2 To the complet	Medical	one) 2 Medical Exami	iner: On the basis of exa and panner stated	amination and/or in	nvestiga	ion, in my opinior	, death occurred	at the time, date	and place, and due	to the cause(s)	
	F > F 3	ğ	29b. Signature and title of certifier	//			29c. Licens				29d. Date signed (Month, Day, Year)	
		ı	O.C.M.E					W.E.		November 1	8. 2007	

GE INE State

Registrar

DHMH 17 Rev 1/2001 OCME 2006 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Rippe MD. Deputy Chief Medical Examiner

31. Date filed (Month, Day Year)

Funera Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physi /Med Exam

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar	Cer	tificate of Death	Reg.	No. 2007	38403			
cian	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death			
lical	CHARLES	W SIN		NOVEMBER	14, 2007	9:54A M			
iner		HOSPITAL	4b. City, Town, or Location of Deat FREDERICK]	4c. County of Death FREDERICK				
1	5. Social Security Number 6. Sex 1 215-20-8644 1 25	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthp Cour. Was	hlace (State or Foreign htry) h D C			
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		1	0d. Inside City Limits			
Director	MD Frederic		Middletown			1 ½ Yes 2 □ No			
al Dire	10e. Street and Number 11 Ali Dr		10f. Zip Code 21769		Dg. Citizen of What Country? USA				
by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No + J - J	Vas Decedent of Hispanic Origin? (\$ f Yes, specify Cuban, Mexican, Puer □ Yes 2 1 Specify:	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
Completed by	15. Decedent's Education (Specify only highest grade compl	16a. Deced	ent's Usual Occupation kind of work done during most of wo IO NOT use retired)	rking 16b	Kind of Business/Inc				
Jdmo	Elementary/Secondary (0-12) Coll	lege (1-4or 5+)	oo NOT use retired) Otain	h	C Metro olice de	_			
Be Co	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid		Po			
To B	Charles William	Sine Sr	Ethel	Viola E	verhart				
	19a. Informant's Name/Relationship (Type. Print Rose E Sine (Wife)		g Address (Street and Number or RAli Dr., Middl			Code)			
	20a. Method of Disposition 1 □ Buria 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place) ed cemetery11/		Location - City or To				
	21. Signature of Furieral Service/Ligensee	Dr. P	onald B. Thomp	son Funer	ral Home MD 217	69			
	shock, or heart failure. List only one cau Immed I ause (Final disease or condition resulting in death)			c or respiratory arrest,		Approximate Interval Between Onset and Death			
.	Sequentially list conditions								
Examiner	Cause (Disease or injury that initiated events	do to (or as a consequence or).							
		ue to (or as a consequence of):							
Medical	I S S S S S S S S S S S S S S S S S S S								
Physician/	in the past 12 months		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year			
ed by Ph	Part II. Other significant conditions contribution Africal fibrilla	g to death but not resulting in the un んつい	derlying cause given in Part I.		co use contribute to the				
Completed by				24a. Was an autopsy performed 1 Yes 24	death?	psy findings available mpletion of cause of 2 No			
Be	25. Was case referred to medical examiner?			ath (Check only one)					
. To	1 ☐ Yes 2 ☑ No Hospital: 27. Manner of Death 28a.	Date of Injury 28b. Time of	Other: 4 Nursing I	lome 5 ☐ Residence		y)			
ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No						
Certification:	3 Suicide 6 Could not be determined 28e.	Place of injury - At home, farm, stre- building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,			
Medical C	(Check only 2 Medical Examiner: On	g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Me	29b. Signature and title of certifier	Vac Our	29c. License number 29d. Date signed (Month, Day, Year) 11-17-07 (Type, Print) S-Chuch St. Middlefown, MD 21769						
<	- James -	Mark Mark	172048		-171-0	(
	30 Name and address of person who complete	d cause of death (Item 23a) (Type, F	300 S.Chuch	St. Wid	aletown	, MD 21769			
tate trar	31. Date filed (Month, Day, Year)	Blow & Co	while.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 12, 2007 Physician John Edward Swanson 12:04pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3501 Forest Edge Drive, #3B Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 215-34-7124 Director 70 24, 1936 Connecticut Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 Forest Edge Drive, #3B 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ No
If Yes, Give
Year or Dates: 1954-62 1 Never Married 2 Married 1 ☐ Yes 2 🗗 No Specify. Specify: White ģ 3 ☐ Widowed 4 🎦 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Director of Internal Auditing | Bell Atlantic Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellsworth Carl Swanson Veronica Mary Connelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Swanson/ Son 3065 Raintree Road, York, PA 17404 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 15 20c. Location - City or Town, State 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Example 10 July 20 Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 Tes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔽 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 CxCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

20+1

29b. Signature and title of certifier

Daphha Henkin, MD

NOV 15 2007

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. egistrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

29c. License number

D53528

18121 Georgia Avenue, #103, Olney, MD 20832

29d. Date signed (Month, Day, Year)

November 14, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 820AM Jauer Dr unn 10 vem Der 13, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner lohn HOSPITAL CIty 8. Date of Birth 12-27-1922 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs **Funeral** Months 1**X** M 2□ F Days Hours Illinois 84 Director 221-22-9626 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at Yes 2 No Director Seaford Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Arbutus Ave 19973 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1942~ 145] Yes 2 □ No If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify. Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Auril Sauerbrunn Lola Miller ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Arbutus Ave, Seaford, DE 19973 Lila Lee Sauerbrunn - wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20/07 Bear, DE 4 □ Donation 5 □ Other (Specify) 21. Signatu a of Funeral 22. Name and Address of Facility
Cranston Funeral Home Cranston John W. P O Box 967, Seaford, DE 19973 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Severe nours disease or condition resulting in death) /Medical Due to or as a co Due to (or as a consequence **Examiner** DY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transi Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year the 9☐ Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 2X No certificate current or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💥 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide the Hospital 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 1 4 2007

Monica

. MAGNICAL POCTOK

30. Name address of person who completed cause of death (Item 23a) (Type, Print)

5. Burgo

29c. License number

Hopkins Hospital, Houth Wolfe Street, Baltimone, Many and 21237

29d. Date signed (Month, Day, Year)

Nacmber 13, 2007

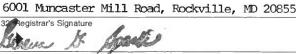
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician Uza Henry November 13, 2007 8:57 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville. Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 | F Director 578-60-4134 71 June 4, 1936 Peru Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show a or 28a-f show be notified at 1 ☐ Yes 2 No Director Montgomery Olney Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18612 Hedgegrove Terrace 20832 USA items 23a death \ Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 🔀 No Specify. Specify: Asian à 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matsu Uza Tokua Uza ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew M. Uza/Son 1415 Key Blvd, # 205, Arlington, VA 22209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1ÆBurial 2 ☐ Cremation 3 ☐ Removal from State Nov. 17, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of) attending physician certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No the 9□Unknown 9 I Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy performed? this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence MOther (Specify-Hospice Facility Hospital: 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide I 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifier 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) D64615 roll November 14, 2007 w

State Registrar 31. Date filed (Month, Day, Year) NOV 15 2007

Genevieve Wroblewski, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Box 68760,

P.O. |

Records,

Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38407 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 24, **Physician** Virginia 5:15 a M Weller 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day) **Funeral** Months Days Hours Min. 214-32-2769 1 □ M 2 🔀 F 88 Jan 4, Mary Land Director Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a, State 10h. County 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2 X No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or rury or other traumatic event, the Medical Examiner must be rury or other traumatic event, the Medical Examiner must be r 6018 Pleasant Drive 21703 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White 3 N Widowed 4 Divorced Year or Dates: 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Jefferson Frederick Keller Lottie ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Houck, Daughter 126 Savannah Court, Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Olivet Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H important: If ite any injury or ot once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 27, 2007 Frederick, Maryland 5 Other (Specify) 4 Donation 22. Name and Address of Facility Reeney & Basford P.A. Funeral Home Funeral Service Lice's 21. Signature 106 East Church St, Frederick, Maryland 21701 M00706 Part! Enter the dicease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial disease or condition resulting in death) Minutes /Medical Due to (or as consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to (or as a nonsequence of) Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate | 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 (Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 □ Yes 2 □ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

0

30. Name and (oddress of person who completed cause of death (Item 23a) (Type, Print)

-andi

32 Registrar's Signature

Suced

31. Date filed (Month

Day, Year)

11-26-07

TOLL House Ave, Frederick MA

07-08992 Heidi Marie Wheat Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

eidi Marie Whea	1	State of Maryland / Department of Health and Menta 1- For State Certificate of Death		eg. No. 201	07 3840
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	th	3. Time of Death
Medical Examin	er	HEIDI MARIE WHEAT		Day Year r 21, 2007	0321 hrs
(F	ľ	4a. Facility Name (if not institution, give street and number) Chester River Hospital Center 4b. City, Town, or Location of Chestertown	Dealit	Kent	
Funeral	•	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		rth(MM/DD/YYYY) 9. Bi Forei	
Director		218-19-8418 1 M 2 X F 19 Yrs. Months Days Hours	Min. Feb		ountry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* .		MD Kent Chestertown			1 X Yes 2 No
/ U	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
with the Maryland ns 23a or 28a-f sho		101 Morgnec Rd. Apt. G-201 21620		U.S.A.	Landing Block
th with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig 1 X Never Married 2 Married 4 Married 5 Married 7 Married 7 Married 8 Married 9 Married 12. Was Decedent U.S. 13. Was Decedent of Hispanic Orig 15 Yes, specify Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	0- 14. Race - Ame White, etc.	erican Indian, Black,
er dea		1 Yes 2 No 1 Yes 2 No specify:		Specify: Wh	nite
ours af	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give king most of working life. DO NOT		16b. Kind of Business	s/Industry
0036 within 72 hours after death with the Maryland gione. rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 Cashier		Gas Stat	ion/Market
21215-0036 ould be filed within 72 h 4 Mental Hygiene. s marked other than "n ite event, the Medical E	E I		's Name (First, Middle,		
215 be file ntal Hy rked o	Be	Louis William Wheat Eli	izabeth A	nn Fahrma	n
D 21 should nd Me is ma	٤	19a. Informant's Name/Relationship (Type, Print) Elizabeth Wheat (mother) 101 Morgnec Ro			
nore, MD 2 ages 1 and 2 shou or of Health and N: f: If item 27 is n other traumatic	-	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State Kent Cremation	11/22/07	Smyrna,	DE.
Baltimo permit. Page Department Important: injury or otl	ł	4 Danation 5 Other Specify: 21. Skent of Funeral Sovice Disappee Galena Funera	al Home c	of Stepher	L. Schaec
ii. II De		M00510 118 West Cros	ss St. Ga	lena, MD,	21635 Approximate Interval
Physician Medical		failure. List only one cause on each line.	ardide or respiratory a		Between Onset and Death
aminer	- 1	Immediate ause (Final disease or condition resulting in death) a Idiopathic julmonary hemosiderosis Due to (or as a consequence of):			
		Sequentially list conditions, b.			1
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			y4.
mg a sign	Examiner	events resulting in death) Last Due to (or as a consequence of).			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	Physician/Medical	X UNPENDED AMENDED, 27, perME, g874, 12/13/07 TT			
760, cate be physic he bur	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	- 1	23d. Date of deliv Month	very Day Year
30x 6876 death certificat e attending phy I for use as the	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopi 4 Pregnant at time of death 5 Other (Specify)	c pregnancy	Month	Day 166
Box e death the atte	hysi	1 Yes 2 No 9 V Unknown 9 Unknown	Loos Die	tobacco use contribute	to the cause of death?
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Vita ysician his cer directo	To Be	examiner? Hospital: 4 Inaction 2 of EP/Outpatient 3 DOA Other	Nursing Home 5		ther:
n of ing Ph After t uneral	ī.			ne how injury occurred	
livisior I or Attend after death. Director:	catic	2 Accident Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, c		n (Street and Number or	Rural Route Number, City
Division of the safe of the sa	Certification:	3 Suicide 6 Could not be determined (Specify)		n, State)	
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	al Ce		lace, and due to the c	ause(s) and manner as	stated.
To the within To the comple	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated. 29c. Signature and title of certifier.		29d. Date signed	
	Σ	29b. Signature and title of certifier O.C.M.E.		November 21	
		30. Name and address of person who completed cause of death (Item 23a)			
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8, per FH, 0874 12/3/07 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day ewis Hnderson 26 2007 VOVERIBER /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSPITAL Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-60-386 Days Hours 1 M 2 □ F Min. 02/21/1961 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 27 is marked other than "natural" or items 27 is marked other than "natural". 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Baltimore Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Yes G 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done-of-fing most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Be Andersor ဥ 19b. Mailing Address (Street and Number o mant's Name/Relationsl thaterson! 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1XBurial 2 □Cremation 3 □Removal from State marrison 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease Atheroscherotic Heart Physician /Medical Due to (or as a consequence of): **Examiner** y peor Ten sion Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Diabete requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Ninknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has I autopsy performed death? 2 No Vital 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be examiner: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA Medical Certification: To 1 Inpatient Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 MNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00 5455 November 26,2007 hysici Ani and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITA Le In Mr 32.:Registrar's Signature OCRI Agnes CIC State Registrar

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State Registrar Bichhuong

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 20b, perFH, C874, 12/14/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Year Month November **Physician** ROBERT 3 2007 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Hopkins Ito Johns 1 ta Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 **3** M 2 □ F Yrs Director 215-30-9423 Md. Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand in Mantal Hygiene.
and it if team 27 is marked other than 'naturel', or Itema 23a or 28e-1 show and it if the or other treumatic event, the Madicial Examinac must be notified at ury or other treumatic event, the Madicial Examinac must be notified at 1 ¥ Yes 2 □ No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1218 Ensor Street 21202 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (₹)Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Crossing Guard 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anderson Anderson Lethia Bud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 1218 Ensor Street, Baltimore, Md. Mildred Anderson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 TBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/1 permit. Page Department of Important: If eny injury or once. Garrison Forest Vetj Owings Mills., Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East Bla 21202 1101 E. North Ave., Baltimore, Md. wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** INFARCTION MINUTES /Medical Due to (br as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 11/4/ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No efter death.

Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient → ER/Outpatient 3 ☐ DOA Medical Certification: To Yes 2□ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours e To the Funerei E Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

32. Registrar's Signature

anna Name and address of person who completed cause of death (Item

ORIGINAL

29d. Date signed (Month, Day, Year)

600 N. WOLFEST. BALTIMORE MD 21787

NOVEMBER 24, 2007

		1 _ State	State of Maryland		artment of h		nd Mental	Hygiene Reg. No.	2007	00111	2
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/Medi	cal	Maresa 4a. Facility Name (If not institution, give si		COII	4b. City, Town, o	or Location of E	Nov		20°07 County of Death	2100 M	
Exami	ner	Laurel-Regional			Lau	ırel		P	rince G		
Funeral Director	1	5. Social Security Number 579-84-6231 $^{6. \text{ Sex}}$	7. Age (In yrs. last		If Under 1 Year Months Days		Min. (Month	of Birth 11, Day, Year) 124, 1	9. Birthp Cour 957 Was	place (State or Foreign htry) h.D.C.	n
το		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					0d. Inside City Limits	3
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with the	Funeral Director	10e. Street and Number 8712 Chestnut	t Ridge Driv	7 e	10f. Zip Code 2 0 7	707			zen of What Coul	ntry?	
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all yich should nd Mer marke marke	10	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address <i>(Stree</i> Chestr	t and Number				Code)	
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ages 1 ant of H it: If ite y or oth		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	ce	metery, cre	osition (Name of matory or other pla	ece) Pk 11	Date . – 1 6 – 07		cation - City or To aurel , M		
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the dea / the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ X No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)			_	Month	Day Year	
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Attending Physician: The reach. The actual reserving the reach. Sector: After this certificate has yet the funeral director, page	ion: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	We	ury at ork?]Yes 2 □ N		cribe how inju	ry occurred		
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spital o		29a. Certifier 1 **Certifying Phys	ician: To the best of my know	vledge, dea	th occurred at the	time, date and	I place, and due t	to the cause(s	s) and manner as	stated.	
the Ho hin 24 h the Fui	Medical	one)	ner: On the basis of examinati and manner stated.	ion and/or i		opinion, deat	h occurred at the		d place, and due		
To vit	2	29b. Signature and title of certifier	neads	W	/ 1	9220			7.14,20		
12		30. Name and address of person who co Neil A. Meade M.	D. 9811 Mal	lard	Dr.Lau	rel,MI	20708	3			
S Regis	tate trar	31. Date filed (Month, Day, Year) DEC 0 3 20	32. Registrar's Signat	ure	Carles						_

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

	For State	State of	Maryland / Dej	partment of He	alth and Me		•	
	Registrar 1. Decedent's Name (First, Mid	dle, Last)	C	ertificate of D	2	Reg. No.		3 BJ 3
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Funeral Director	5. Social Security Number 217-50-506	1 1 M 2 N	7. Age (In yrs. last birthda 7. Age (In yrs. last birthda		If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Year)	Cour	place (State or Foreign ntry) Aryland
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ovember am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner General HOSPI Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Hours Min 1 ☐ M 2 🗹 F Days Director aryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov must be notified at 1 Kes 2 No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2122 arrolton death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) mentary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F JKNOWN မ 19a. Informant's Name/Relationship (Type. Pr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod) Department of Health ar Important: If item 27 Is any Injury or other trau Michael 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Pages 1 **3altimor** 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 9-1215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHU **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5/ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner the death certificate be executed tension use as the burial-tran Que to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy for in the past 12 months? Day Year 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ 9 ☑ Unknown o. 2 No ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1□ Yes 2 **2** No or Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 No 1 ☐ Yes 1 thpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred After Year 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No after death the f 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 L ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ryland GreneRal Hosp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 81304 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** imore enu 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X**M 2□ F 215-16-0733 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ortant; If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important; if Item 27 is marked other the any Injury or other treasment. rier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 21 19a. Informant's Name/Relationship (Type. nton A Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 R 3 ☐Removal from State 21. Signatur Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tastation 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 20 No မှ 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 | Inpatient this 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director; After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 29a. Certifier 🛚 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar tieR.

31. Date filed (Month, Day, Year)

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1650 Orleans Street Baltimore Maryland 21231

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 27 /Medical L. Buttner NOVEMBER 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES N/A HOSPITAL BALTIMORE if Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Yrs. Director 217-12-7001 Jan. 7,1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notifled at 1 ☐Yes 2 ☐ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Light Street Apt. 931 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Payrol1 Proctor & Gamble 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Buttner Georgie Ε. Wolfe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome F. Bowen (Nephew) 391 Ironwood Court Millersville Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 12/1/07 Brooklyn Park Maryland 4 □ Donation 5 □ Other (Specify) McCully-Polyniak Funeral Home, P.A. 130 East Fort Avenue Baltimore, Maryland 21230 21. Signature of Funeral Service Licensee 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Cerebrovasula 3days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hbilla hor arrial Sequentially list conditions, any facility in madelicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 400rs Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an Division or Vital 2 **X**No the Hospital or Attending Physician: ' Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 [x]npatient 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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Registrar

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900 South

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)
DEC 0 3 2007

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Balhmore MD

November 27, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** BETTY J. BURTNICK 7:50 AM DECEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL N/A HARBOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F 217-26-4449 Director Dec. 23, 1928 <u>Maryland</u> Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f shov notified at N/A 1 Yes 2 □ No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be a 1822 Byrd Street 21230 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White \$ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Beautician permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert A. Kreuger Sarah Tregoe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1822 Byrd Street, Baltimore, Maryland 21230 Elmer Barnheart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 12-04-07 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Euneral Service License McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I remediate Cause (Final Isease or condition resulting in death) Physician ACUTE MYOCARDIAL INFARCTION 14 HOURS /Medical Due to (or as a consequence of) **Examiner** CARDIOGENIC HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPER TENSION Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No ATRIAL PAROXYSMAL 24a. Was an 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar

Palepu

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

RESØØØØ

DECEMBER 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANOVER ST

and manner stated

BALTIMORE

MD 21225

PALEPU 31. Date filed (Month, Day, DEC 0 Year) 0 3

(Check only one)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 17, 2007 7:36 AMM James Richard Boone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Gilchrist Center</u> Towson Social Security Number 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1∏M 2□F Days Hours Min. Director 78 Mar 6, 1929 Maryland 214-26-7665 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2√ No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Skylark Court #D 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Ty Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ white Specify: 3 ☐ Widowed 4 ☐ Divorced 155-57 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 merchant seaman shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Thomas Boone Mabel Alverta Gilland 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other traus 7 Skylark Court #D Parkville, MD Maybelle Boone/spouse 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director min TBaltimore, MD 21201 23a. Part1. Enter the disease, or o implication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UNG disease or condition resulting in death) Cancer aum /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ObSANUCMY Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No performed? 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? ral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Will W 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending thin 24 hours after death.
the Funeral Director: A
mpletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ithin 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 058303 Nevember 18 2007

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P.O. Box 68760

Division or Vital Records,

Registrar

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31. Date filed (Month, Day, Year) DEC 0 3 2007

N. Chimles ST Trisen MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

			1- For State of Maryla Registrar Amend #7, perFH, C874, 12/4/07		artment of I rtificate of		d Mental Hy		007 3841
I L	200		1. Decedent's Name (First, Middle, Last)	11 001	Timodic of	Death	2. Date of D	eath	3. Time of Death
	Physici /Medi		Thomas Hutchinson Botts, III				November 1	er 26. 20	Year 007 1:18 pm M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of De		4c. County	
		s - A	3831 E. Joppa Road Apt. T3 5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 F	frs. 8. Date of B		more Co.
	Funeral Director		261-70-8312 1√2 M 2□F 63	Yrs.	Months Days		lin. (Month, D	ay, Year) 16,1944	9. Birthplace (State or Foreign Country) Ohio
A.C.	p ,		Usual Residence of Decedent				nugust	10,1744	
	shov	5		City, Town or Lo					10d. Inside City Limits 1 □ Yes 2 No
	the N 28a-1 notiff	rect	10e. Street and Number		10f. Zip Code			10g. Citizen of V	
	h with 23a or st be	Funeral Director	3831 E. Joppa Rd Apt T3		21236			U.S.A.	
	ems er mu	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Decedent of I	Hispanic Origin?	(Specity Yes or Nuerto Rican, etc.)	o- 14. Rac	e - American Indian, ck, White, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☒ Divorced Year or Dates:		1□Yes 2█No		,	Specify	
8	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	ted t	15. Decedent's Education		dent's Usual Occu			16b. Kind of Bu	usiness/Industry
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21	led wi tygien her th nt, the	S	12	Comba	t Contro			1	Force
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last) Thomas H. Botts, Jr.				Name <i>(First, Middle</i> s Mary Hu		ne)
ary	shoul ind Me i mark umati	2	19a. Informant's Name/Relationship (Type. Print) (Brother)) 19b. Mailir	ng Address (Stree	l t and Number or	Rural Route Num	ber, City or Town,	State, Zip Code)
	and 2 ealth a n 27 ls		Bertram E. Mooney, Jr. (InLaw)	·			tingham :		
ore	ges 1 t of He if Item or oth			Place of Dispo cemetery, crei	osition (Name of matory or other pla	ace)	Date	20c. Location -	City or Town, State
Baltimore,	t. Pag tment tant: ijury o		2 - 11		Crematory		28/07	Baltimo	re, Maryland
Ba	permit Depar Impor any ir		21. Signature of Funeral Service Licensee		2. Name and Addr '05 Belai	r Rd S			Home, Inc.
п	s \$		23a. Part1. Enter the disease, or complications that caused the dec shock, or heart failure. List only one cause on each line.			K	altimore	, Md 212: arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	ANC					Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conse						2000
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enta Underlying Cause (Disease or injury that initiated events c.	4					
0,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a conse	quence of):					
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9	that the death certific ed by the attending p detached for use as i	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregr	nancy				001.0	
Box	d for u	ician	23b. Was decedent pregnant in the past 12 months? 1	tal death 3 🛭	Ectopic pregnand Other (specify)	су			te of delivery onth Day Year
P.0.	at the oby the tached	hysi	9 ☐ Unknown 9 ☐ Unknown						
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orc	w requir been si should I	eted	SEVERE EMPHYSEMA	-			- 1X	Yes 2 No	3 Probably 4 Unknown
Rec	ne law has b ge 2 s	Completed					– 24a. Was	ppsy	Were autopsy findings available prior to completion of cause of death?
ta	siclan: Th certificate rector, pag		25. Was case referred to medical			26 Place of I	1 Yes Death Check only	2 No	1 ☐ Yes 2 ☐ No
Ž	shysich this cer al direct	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatier	nt 3 DOA Oti	her: 4 Nursin	1.0	idence 6 □Oth	er (Specify)
Division or Vital Records,	Attending Physician: r death. ector: After this certific. by the funeral director, I	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)	28b. Time of	Wo		28d. Describe	how injury occur	red
isio	death.	icati	2 Accident investigation 3 Suicide 6 Could not be 389 Bloom of injury. At h	home farm etc		Yes 2□No	29f Logation	(Street and Numb	on or Burel Baute Mumber
Di∨	ospital or Attend hours after death, uneral Director: / ly filled in by the f	Certification:	4 Homicide determined building, etc. (Special	ify)	eet, factory, office		City or To	own, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Salc	29a. Certifier (Check only (Ch	nowledge, death	h occurred at the t	ime, date and pl	ace, and due to the	cause(s) and ma	anner as stated.
	To the H within 24 To the Fl complete	Medical	one) and manner stated.	auon and/or in			ccurred at the time		
	wit To	Σ	29b. Signature and title of certifier		29c. Licens	_		29d. Date signer	d (Month, Day, Year)
,	, S		30. Name and address of erson who completed cause of death (Ite	m 23a) (Tyne				1. ~0	
l	0		SEIN AUNG, 9103 FRANKLIN			#2200	, BALTI	nore mi	21237
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Sign DEC 0 3 2007		1 10				

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

DEC 0 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 38421 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Thomas Bogier 11 28 6:30a2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2618 Biddle Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min. 1 ★M 2 F 59 216-50-0415 Director 4-22-1948 Md. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director Md. NA Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 2618 Biddle Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 😥 No Specify ۾ Black 3 Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9th grade Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Thomas Bogier Willie Mae McIntosh ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Jacqueline Clayton Sister 2618 E. Biddle Street, Baltimore, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mt. Carmel Cem. 12-4-07 Dundalk, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. w ama 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cell UHEROW /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran attending physician and Due to (or as a consequence of): THOMAS (30句) E Box 68760, Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' this certificate il or Attending Physician: after death. Director: After this certifica Home 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 150ice 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifies Medical (Check o one) 29c. License number 29b. Signatur

State Registrar BIVED

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Bultime MD 21210-1303.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Carter, Jr State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year November 22, 2007 Medical Examiner 1135 hrs WILLIAM CARTER, JR.
4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 3700 West Belvedere Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Country) MD 1 X M 2 JULY 22 1960 Yrs 212-76-8570 47 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No 28a-f show WOODLAWN with the Maryland BALTIMORE rector ME s 23a or 28a-f e notified at o 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ā USA 21207 6253 ROBIN HILL Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No Yes Specify: BLACK 4 Divorced If Yes, Give Year Yes 2 X No specify: 3 Widowed þ or Dates Pages I and 2 should be filed within 72 hours. nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natur: ry other traumatic event, the Mydical Exami 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 **ASBESTOS** LABORER 12TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be ALMETTA MCKINNEY WILLIAM CARTER. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WOODLAWN, MD 21207 6253 ROBIN HILL RD., ANGELA CARTER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 8710 DOGWOOD RD. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/30/2007 WOODLAWN, MD 21207 KING MEMORIAL PARK Donation 5 Other Specify: è 22. Name and Address of FacilityWESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licenses 2007-09 EASTERN AVE. BALTIMORE, MD 21231 that caus whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval nter the diseas or complic **Physician** failure. List only one wuse on each line Between Onset and 'Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transi Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death. Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Day Year 1 ive birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has death? performed? ✓ Yes 2 25. Was case referred to medical 26 Place of Death (Check only one Be Other₄ examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes ဥ 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Driver motorcycle auto collision Nov 22, 2007 Natura 1125 hrs Yes 2 V No d in by the Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 3700 West Belvedere Avenue , Baltimore , MD determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 23, 2007 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registrar

Melissa Brassell, MD

31. Date filed (Mo

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1760130181	ificate of Death	Reg. No. 200	7 3842
Physician Medical Examine	er JASON TUCKER COBU	URN	2. Date of Death Month Day Year November 29, 2007	3. Time of Death 0215 hrs
	Facility Name (if not institution, give street and number) A400 Block of Mountain Road	4b. City, Town, or Location of De Pasadena	ath 4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. las 19			thplace (State or gn untry)Maryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Town or Location		10d. Inside City Limits
Aaryland 28a-f show Lat once,	Maryland Anne Arundel	Pasadena		1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 381 Dutchship Road	10f. Zip Code 21122	10g. Citizen of What Cou	
21215-0036 Memal Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once.		 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes 2 X No specify: 	Specify Yes or No- rto Rican, etc.) 14. Race - Amer White, etc. Specify: Wh:	ican Indian, Black,
hours a	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done 16b. Kind of Business/ retired)	Industry
0036 within 72 iene. er than Medical	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	Student	Colleg	ge
21215-0036 July be filed within 72 hours a Menal Hygiene. marked other than "natural cevent, the Medical Examin	77. Father's Name (First, Middle, Last) Richard B. Coburn		me (First, Middle, Maiden Surname) san A. Greenhorn	
ID 2121; should be fill and Mental F 7 is marked natic event, I	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State	
Z G H G H	Richard B. Coburn (Father) 20a. Method of Disposition 20b. Pi	309 A. Lots Road, S	tevensville, Marylar	
MOF6 Pages 1 ent of Fi	. Donar E - Ordination o Tremoval nom State		1-30-07 Baltimore	
Balti permit. Departm Importa	- fund & found	McCully—Polyniak 3204 Mountain Ro	Funeral Home P.A. ad, Pasadena, Maryla	and 21122
Physician /Medical	236 Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	Do not enter the mode of dying, such as cardia	c or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
xaminer	or condition resulting in death) Due to (or as a consequence of)	i i		
led nsit Evaminor	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisbase or injury that immand			
ecuted and and - transit		£**		
760, cate be execuphysician and the burial - tra	UNPENDED AMENDED			
c 687	2 IZ3D Was decedent pregnant in the	2 Fetal death 3 Ectopic pre	gnancy 23d. Date of deliver	y Day Year
that the death ned by the att detached for the structure of the structure		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
S, P.(<u>े</u>		1 Yes 2 No 3 Pro	bably 4 🗸 Unknown
of Vital Records, g Physician: The law require. ther this certificate has been signeral director, page 2 should be				utopsy findings available completion of cause of
tal Rec		26.Place of Death (Che	1 Y Yes 2 No 1 Y Y	es 2 No
f Vital Physician: er this certifi and director,	1 Yes 2 No Inpatient 2 E	1Othor:	rsing Home 5 Residence 6 Othe	r: Scene
	1.27 Manner of Death 128a Date of Injury	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject driver of vehicle in vel	nicular accident
Division ospital or Attendi hours after death. meral Director: /	3 Suicide 6 Could not be determined (Specify) Local Street	ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ri or Town, State) 4400 Block of Mountain Road, Pas	
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Zya. Centrer			
Fride	29b. Signature and title of certifier	29c. License number O.C.M.E. 00	ME 29d. Date signed (Mo	• .
4	30 Name and address of person who completed cause of death (Items	no	140 verilber 29, 2	
10	Theodore M. King, Jr., MD. Assistant Medical Example 31. Date filed (Month, Day, Year) 32/Registrar's Signature		ore, MD 21201	
Stat Registra		South		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 107

			For State Registrar	olate of Maryland		rtificate of L			Reg. No.	07	38424
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	/Media			ornish				11	28 2	2007	20:50 pm
S	Examin	er	4a. Facility Name (If not institution, give s Good Samar, ta	treet and number)		4b. City, Town, or Baltim			4c. County	of Death	
- //	Funeral		Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthpl Count	ace (State or Foreign
	Director		129-26-8185 Usual Residence of Decedent	80	Yrs.			06/23/			Carolina
	yland Jow at		10a. State 10b. County	10c. City, To	own or Lo	cation				10	Od. Inside City Limits
	a-f sh	ctor	Maryland			Baltimo	re				1 XYes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Count	try?
	s 23a	ral	4700 Frankford Ave		1		21206		U.S.A		
980	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	- 1	Was Decedent of His if Yes, specify Cubar 1 □ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ресіfy Yes or No o Ricaп, etc.)	Blac	e - America k, White, e g: Blac	etc.
21215-0036	nin 72 ho s. In "natur Medical E	Completed	15. Decedent's Educ (Specify only highest grade	ation 1. completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of worl	king	16b. Kind of Bu	usiness/Ind	ustry
7	d with	Com	12	College (1-401 34)		Nurs	e		Medi	cal	
ng	be file Ital Hy doth event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Surnam	ne)	
Maryland		၉	Goldie Bellamy	. 5:0			Martha C				
<u>a</u>	au au		19a. Informant's Name/Relationship (Typ	· · · · · · · · · · · · · · · · · · ·		ng Address <i>(Street a</i>					
	ges 1 and 2 it of Health If item 27 or other tra	-	Stanley Cornish / 1 20a. Method of Disposition	20b. Place	of Dispo	Frankford sition (Name of		Date	20c. Location -		
timore,	0 0 - -		1 Burial 2 ☐ Cremation 3 MRe 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place	· !	0 /2007	Tona Tal	- And	Norr Vowle
a	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	PINE	Lawn 22	Cemetery Name and Addres	s of Facility The	Derric	k C Jor	nes F	New York
<u> </u>	8 9 E 8 8		- July C		46	11 Park H	ats. Ave	. Balt	imore. M		
M			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations the caused the death. De cause on each line.	o not ente	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pulmonary		ibrosis					Onset and Death
	Examiner			Due to (or as a consequent	ce of):						
3		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent	ce of):						
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events								
Ö,	e exe ian ar urial-t		resulting in death) Last	Due to (or as a consequence	ce of):						
68760,	rtificate be executed ng physician and as the burial-transit	Medical	d.					<u></u>			
9 xo	certific ding p		IF FEMALE:	c. If yes, outcome pf pregnancy						77 18	
P.O. Bo	The law requires that the death cer tte has been signed by the attendir bage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3□	Ectopic pregnancy Other (specify)				te of deliver	ry Day Year
ت. ت	s that ned by deta		Part II. Other significant conditions conf	ributing to death but not resulting	g in the ur	nderlying cause give	n in Part I.	23e. Did t	tobacco use contr	ribute to the	e cause of death?
Vital Records,	w requires that the d been signed by the should be detached	Completed by	Hypertension					10	Yes 2 No	3 ☑ Proba	ably 4 Unknown
000	law re as bee 2 sho	plet						24a. Was	an 24b. \	Were autop	sy findings available apletion of cause of
ř	The ate his page	Com				<u>-</u>		autoj perfo	ormed? c	prior to com death? I∐Yes	
Vita V	s ici an: The law certificate has l irector, page 2 s	Be (25. Was case referred to medical examiner?				26. Place of Dea				
o	Physi this o	<u>۲</u>	1 Yes 2 No	ospital: 1 ☑Inpatient 2 ☐ ER/ 28a. Date of Injury 28	Outpatien b. Time of		4 LI Nursing H		dence 6 □Oth)
on	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	at ? ′es 2 □ No	28d. Describe	how injury occurr	red	
Division or	r Atten er deat rector by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home, building, etc. (Specify)	farm, stre			28f. Location (Street and Numb	er or Rural	Route Number,
5	ital or ris after ral DI led in	Cer									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, E.	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physical Examin	cian: To the best of my knowled er; On the basis of examination and manner stated.	dge, death and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
	To the To the To the Somple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	d (Month, L	Day, Year)
			> Hulch	, MD		RES	-000		11/	28/	2007
•	5		20 Name and address of parson who cor	nalated agus of death (Itam 33	a) (Type,	Drine\					
	2		Natallia Monoz	5601 Loch RG 32 Registrar's Signature	ven	Blud, 1	59/timo	re, M.	0,21.	239	
	Sta Registr	-	31. Date filed (Month, Day, Year) DEC 0 3 200	7 September 2 Signature	60	Will.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Month 1:27 PM aro November 200 4b, City, Town, or Location of Baltimore 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death Johns Hopkins HOSPITZU 8. Date of Birth (Month, Day, Year, 06-10-1961 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days 1□M 2\ F Months Hours 215-86-0521 46 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Cedar Church Rd 21034 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 Medical Billing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Anderson Delores Caplan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3332 Cedar Church Rd Darlington, MD 21034 Charles Csillag (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12-03-2007 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Homes, Inc. 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Middle havs Due to (or as a consequence of): cteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Abscass Due to (or as a consequence of) Michalogenous IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

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filed within 72 hours after

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permit. Pages 1 an Department of Healt Important: If Item 27 any injury or other tr.

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Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day Year)

Michael R. gu Col, MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

all the

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician; n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by t death.

To the within 2.

State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

GRUNWALD, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BASTIMORE, MARYLAND

29d. Date signed (Month, Day, Year)

November 28, 2007

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 23a per dr., g874, 12603/07dbb of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 26 **Physician** 2007 10:19 p^M Julian Culwell в. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year)
JAN 22 1918 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1**X**M 2□ F 448-32-7695 89 Oklahoma Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21044 6336 Cedar Lane, USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Planographer Automobile permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important; If item 27 Is marked other any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Culwell Thomas Marion Myrtle Fits 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Foerester – niece 2 Kingshouse Court, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/28/2007 Baltimore, MD 21. Signature Funeral Service Licensee H. 22. Name and Address of Facility.

Cremation Society of Maryland, Inc.
299 Frederick Road, Baltimore, MD Williams 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Possible Aspiration sician and burial-tran Due to (or as a consequence of) attending physician I for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a detached for 2 No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Urosepsis 1 TYes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy perform certificate 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 📆 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 ☐ Homicide within 24 hours a filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63343 11/27/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hospital 1500 Forest Glen Road, Silver Spring, MD 20910 32 Registrar's Signature State Registrar

State Registrar 31. Date filed (Month Pay Year)

DHMH 17 Rev 1/2001

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32. Régistrar's Signature

Mary land 21210

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** DAVIS ILDRED NOVEMBER 29,2007 06:35Am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Inder 1 Year | If Under 24 Hrs. HARBUR HOSPITA N/A 8. Date of Birth (Month, Day, Year) If Under 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2☑F Months Days Hours Min 93 Yrs. Pennsylvania Director Mar. 8. 1914 180-01-2454 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Maryland N/A Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 406 Frankle Street 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home \cap 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Crozier Stinner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Vickery (Daughter) 406 Frankle Street, Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 12-03-07 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Fugeral Service Licus McCully-Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Marvland 2122 Approximate Interval Between Onset and Death rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ediate Cause (Final Isease or condition resulting in death) Brain Physician tu mour /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): phevmonia IWERK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

NOVEMBER 29, 2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hanover

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day F. DUNCAN JOHN Dec. 2 2007 1:10 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 7907 Wiltshire Court Pasadena If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 73 Jan. 14, 1934 Maryland 218-28**-**7275 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 MYes 2 □ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 U.S.A. 1621 Webster Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 May Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) J.R. Ritter Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Ε. Duncan Elsie Lathe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 1621 Webster Street, Baltimore, Maryland 21230 Kathleen A. Duncan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 12-06-07 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. art1. Enter the disease, or c shock, or heart failure. List o

Physician /Medical Examiner

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To the Hospina Community 24 hours after death.

To the Funeral Director: After the Funeral Director: After the Funeral Director: After the Funeral Director: After the Funeral Director: After the Funeral Director After Topics A

The law requires that the death certificate be executed

or Attending Physician:

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Division or Vital Records, P.O. Box 68760,

Important: If it any injury or o

Physician

/Medical

Examiner

10a. State

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Man nent of Health and Mental Hygiene.
wit: If item 27 is marked other than "natural", or items 23a or 28a-f sh ury or other traumatic event, the Medical Examiner must be notified.

3altimore, Maryland 21215-0036

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Funeral

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disease or condition resulting in death) Examine

Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

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molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Maryland ZIIZZ Approximate
yone cause on each line. _a. RESPIRATORY FAILURE	Interval Between Onset and Death
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Due to (or as a consequence of):	, , ,
cDue to (or as a consequence of):	
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23c. If yes, outcome pf pregnancy	3d. Date of delivery

Physician/Medical IF FEMALE: outcome pf pregnancy ve birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 pronths? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes

Month

24a. Was an 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2)X No 1 Yes 2 No Daughters

Day

Year

1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient	3 🗆 D	OA Other: 4□ Nur	rsing Home	5 Residence	6 NOther (Specify) Residence
27. Manner of Death 1 Natural 5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ N	280	. Describe how inju	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, street ify)	t, factor	ry, office	28f	Location (Street a City or Town, Star	and Number or Rural Route Number, te)

29a. Certifier

Medical Certification: To Be

25. Was case referred to medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier I. (MEDICAL DOTAL)

29d. Date signed (Month, Day, Year) RES-000 DECEMBER 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIUS HOPKINS HOSPITAL, 401 N. BELADWAY, BALLEMORE MO 21231 EMMANUEL ANTONARAKIS

State Registrar

82. Registrar's Signature 31. Date filed (Month, Day, Year)
DEC 0 3 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 29, Year 7 Month **Physician** 11:554M Novembe HAROLD 0. DOUGLAS JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner en BUTTIL Anny Balto-Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours 218-48-3452 Director July 06, 1948 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Director Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7724 Vena Court 21122 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. Specify: Completed by 3 Widowed 4 Divorced natural", traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene, Important: If item 27 Is marked other than any Injury or other traumatic event, the Me once. College (1-4or 5+) Maryland Racing Jockey 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emelia Litten Harold O. Douglas ပ Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine R. Douglas (Wife) 7724 Vena Court, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville VA Cem. 12-03-07 Crownsville, Maryland 21. Signature of Egneral Service License 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ease or condition resulting in death) **Physician** /Medical sequence of): Examiner Mi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown After this certificate has been signed by interest director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an was an autopsy performed?
Yes 21 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 npatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🚣 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the within 2 and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

DEC 0

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene	U	-)	Ĭ

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	Physicia /Medic Examin	_	Decedent's Name (First, Middle, I	ast)						2. Date of Dea	ith		3. Time of Death	
20			Lucille Novella Day	/is						Month November	Day 26, 2	Year 2007	1:40 PM M	
		_	4a. Facility Name (If not institution, give street and number)			4	4b. City, Town, or Location of Death				4c. County of Death			
4			Frostburg Villa	age			Fr	ostbur	g		A	llegany	,	
ų.	Funeral	355	Social Security Number 6.		e (In yrs. last bi		ff Under 1	Year If Uni	der 24 Hrs. rs Min.	8. Date of Birtl (Month, Day	Year)	9. Birth	place (State or Foreign	
4	Director		233-42-9922	1□M 2∏F	85	Yrs.				June 4,	192	2 Mary	länd	
	pur *		Usual Residence of Decedent 10a. Slate 10b. County		10c. City, Tow	m or Locat	tion						10d. Inside City Limits	
	anyla.	ž											1 ☐ Yes 2√ No	
	he M	Director	MD Alleg	any	Fro	stbur					to- Citi-	en of What Cou		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.	ă	10e. Street and Number 1 Kaylor Circle	#217A			10f. Zip C	21532				ISA	intry r	
		Funerai		12. Was Decedent	Ever in 118	12 Wa			Origin? (Sp	ecty Ves or No-		4. Race - Amer	ican Indian	
	Iten d	'n	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces?	,	If Y	es, specify	Cuban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)		Black, White		
21215-0036	irs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆	Yes 2	No Spec	city:			Specify: wh	ite	
Ą	2 hou	Completed	15. Decedent's	Education	16a	. Deceden	nt's Usual (Occupation			16b. Kin	d of Business/I	ndustry	
2	hin 7 a. Mad	pie	(Specify onfy highest of Elementary/Secondary (0-12)	grade completed) College (1-4or:	5+)	life. DO	NOT use	done during r retired)	most of work	ang				
21	gien gien th	NO.	12	4			co	py edi	itor		jοι	ırnalis	n	
2	al Hygie f other t vent, th	Be (17. Father's Name (First, Middle, La							e (First, Middle,				
<u>a</u>	should be Ind Mental I	ဥ	David Dexter D	avis				No	vella	Lucret	ia Bo	oal		
Maryland	2 sho and le m		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing /	Address (3	Street and Nu	mber or Rui	al Route Numbe	r, City or	Town, State, Z	ip Code)	
	and ealth m 27		Matilda Richards	/sister						Frostbu				
Ore	of H if ite		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	20b. Place o cemete	if Dispositi ery, cremat	ion (Name tory or oth	er place)	1	Dale	20c. Loc	cation - City or 1	Town, State	
Ē	Pages ment of tent: If it		4 ∑Donation 5 ☐ Other (Spec	cify)										
Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Euneral S. Lick	Wade, Dir	ector	Sta	te Ai	Address of Fa natomy	Board	655 W.	Ba1	timore	Street	
	403#4		/ mull	asu				re, MD					Annualizate	
*			23a. Part . Enter the disease, or co shock or heart failure. List on	ly one cause on each li	ne.				as cardiac	or respiratory ar	rest,		Approximate Intervat Between Onset and Death	
	Physician		fmmediate Oause (Final disease or condition resulting in death)	_a You	Cem.	Call	DVR	_ De	prev	alin			5 Weeks	
	Medicale be executed this in the private as the purial-transit		resulting in death)	Due to (or as	a consequence	of):	•		1					
		_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	Due to (or as a consequence of): Dysphagia									
		ulue	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a coffeeddelice	G (1).								
		Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):											
68760,	sicien buria	a												
687	ficate g phy is the	edical		d										
Вох	nding use a	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	3d. Date of deli	very	
m	death a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	In the past 12 months? 1 Ves 2 Value 4 Pregnant at time of death 5 Other (specify)							Month Day Year			
Records, P.O.	t the by the ache	Physician/I	9 ☐ Unknowg	9□ Unknown										
	res that the death ce igned by the attendii be detached for use	by PI	Part II. Other significant conditions	contributing to death b	out not resulting i	n the unde	erlying cau	ise given in Pa	art I.	23e. Did to	bacco us	se contribute to	the cause of death?	
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ed t	_ Ulmentia	- Ce	reprol	/asc	Julan	/ Di	Scar	2 1 DY	′es 2□	No 3∏Pro	bably 4 Unknown	
		piet								24a. Was		24b. Were au	topsy findings available completion of cause of	
		Completed						-		autop perfor	med? 2 X No	death?	2□ No	
ta		Be C	25. Was case referred to medical examiner?					26. P	lace of Deal	th (Check only o	1			
<u>-</u>		2	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ERVO	ulpatient	3□ DOA	Cther:	Nursing Ho	ome 5 Resid	lence 6	Other (Spec	cify)	
Division of Vital			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b.	Time of Injury	280	. Injury at Work?		28d. Describe h				
		ati	Accident investigat				М	1 ☐ Yes 2	2 □No					
Ξ̈	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of in	jury - Al home, fa lc. <i>(Specify)</i>	arm, street					n (Street and Number or Rural Route Number, Town, State)			
	urs al													
	Hospitel 24 hours a Funerel (Medicai	(Check only 2' Medical Ex	Physician: To the best aminer: On the basis of	of examination ar	e, death or nd/or inves	ccurred at stigation, in	the time, date n my opinion,	e and place, death occur	and due to the or red at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	
	To the I within 2 To the I complet	Med	one) 29b. Signature and little of certifier	and manner st	aleu.		29c 1	License numb	төс		29d. Dale	signed (Monti	n, Day, Year)	
)	F M F S		7	1 \	1. 10		•	1/1/1	611	_			-2007	
			70 Non- and add a 2	o complaint	touth (the = 00)	W Com		144	04		- ((~ C	, 2001	
			30. Name and address of person wh		Frostb			00 E-	oath.	rg, MD.	21 5	:22		
	Sta	te	Sikander L. 31. Date filed (Month, Day, Year)	Sandhir 32. Registi	rar's Signature	arg \	ATTIC	Se II	USLDU	ES, MU.		1.74		
	Registr		DEC 0.3	2007	2000 0	1	BARLA							

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nirish

DEC 0

31. Date filed (Month, Day, Year)

9000 Franklin

32. Registrar's Signature

D0063131

November, 27, 2007

Drive Baltimore, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

			For	State of Maryla	nd / Dep	artment of	Health and I	-		1 2 1 1	38433	3
			1 - Stata Ragistrer		Ce	rtificate of	f Death		Reg. No.			
			Decedent's Name (First, Middle, La	est)				2. Date of De Month	ath Day	Year	3. Time of Death	
	Physici /Medio		TIMOTHY	EDWI	41205			NOVEMBE		2007		М
	Examir		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town,	or Location of Deatl	1	4c.	4c. County of Death		
			THE JOHNS HOP	KINS HOSPITAL		BALTIN	MORE CITY	7		N/	A	
	Funeral		5. Social Security Number 6. S		s. last birthday,	If Under 1 Yea		8. Date of Bir	th Year)	9. B	rthplace (State or Foreign	gn
	Director		212-86-7110	10XM 2□F 42	Yrs.	Months Day	s Hours Min.	Sept.	20,	1965 ິ	Maryland	
	D		Usual Residence of Decedent									
	how how		10a. State 10b. County I	1/A 10c. 0	City, Town or L	ocation Ralt	cimore				10d. Inside City Limit	
	Ma B-f-e	ţ	I I I	1711		231	ZIMOI C				MXYes 2 □ N	10
	h the	Director	10e. Street and Number			10f, Zip Code			10g. Citiz	en of What C		
	within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at	a D	5318 Gist Ave	nue			21215			USA		
	deal deal	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	f Hispanic Origin? (S Jban, Mexican, Puerl	pecify Yes or No)- 1	4. Race - An Black, Wh	nerican Indian,	
ထ	or Ite	Ē	1 Never Married 2 Married	1 Yes 2 No				o rican, etc.)			_	
8	alt. c	b	3 Widowed 4 Divorced	Year or Dates:		1 □ Yes XXN	o Specify:			Specify:	Black	
5	2 ho	ted	15. Decedent's E		16a. Dece	dent's Usual Occ	upation ne during most of wo	delna	16b. Kir	d of Busines	s/Industry	
긆	within 7 ene. than "r	ble	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)	King	Dri	vate	Industry	
2	d with	Completed	Ziomoniary/odoonidary (o 12)	1 year		Labor	rer		111	vacc		
Þ	be filed tal Hygird of other event, II	Be C	17. Father's Name (First, Middle, Las					ne (First, Middle		Sumame)		
a	d d d	To B	Charles Edward	ds			Ela	ine Jor	nes			
7	d 2 should th and Men 7 Is marke traumatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stre	et and Number or Ru	ıral Route Numb	er, City or	Town, State,	Zip Code)	_
Š	7 18 18 18 18 18 18 18 18 18 18 18 18 18		Elaine Edwards	/ Mother	531	8 Gist	et and Number or Ru Avenue	Baltimo	ore,	Mary	Tand 2121	5
Baltimore, Maryland 21215-0036			20a. Method of Disposition	20b	Place of Disp	osition (Name of		Date	20c. Lo	cation - City o	or Town, State	
2	ages nt of t: If i		Murial 2 Cremation 3	Removal from State	cemetery, cre	matory or other p	tery 12/	3/07	Lan	awoba	e, MD	
∄	permit. Pages Department of HImportant: If its any injury or of once.		 4 □ Donation 5 □ Other (Special Signature of Fugeral Service Lice 				1					_
Ba	Departing any ir		1 01	-							neral Hom	
			soy Tha	ves						TIMOI	e, MD 212	2 1
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.	ath. Do not en	ter the mode of a	ying, such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
-	Pnysician		Immediate Cause (Final disease or condition	a CARD	IDMYOPA	THY					3 months	
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):							
	LAdmine		Sequentially list conditions.	D	2KALEH	A					1 hour	
-	D =	Examiner	Sequentially list conditions, if any, leading to immediate cause Ent. John No. Cause (Disease or injury	Due to (or as a cons	equence of):							
	ocute ind trans	am	that initiated events	c								
oʻ	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a cons	equence of):							
1760,	icate be physic s the bu	cal		d								
68	tifica ng ph as ti	Physiclan/Medl			_							
Вох	leath certific attending pl	Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		□Ectopic pregnar	201		2	3d. Date of d	,	
	deat e att	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)				Month	Day Year	
o.	t the de by the tached	hys	9 Unknown	9∐ Unknown								
<u>ر</u>	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	by P	Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying cause	given in Part I.	23e. Did 1	tobacco u	se contribute	to the cause of death?	
of Vital Records,	quire n sig							1 🗆	Yes 2	□No 3 □	Probably 4 Unknow	v n
00	w require been si should t	Completed						24a. Was	an	24b. Were	autopsy findings availab	ole
Be	ne lav has ge 2	E						auto		prior to death	o completion of cause of	ıf
				I				1 ☐ Yes		1 🗆 Y	as 2 No	
Ž.	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			3th an	ath (Check only				_
J	this at div	မ	1 Yes 2 No	1 Unpatient 2		IN 3L DOA	4 🗆 Nursing r	lome 5 Resi			pecify)	
	ding h	o	27. Manner of Cath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	W		28d. Describe	now injury	occurred		
Si	Attanding or death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not l	20			□Yes 2□No					
Division	for At after d Direct	Certification:	4 Homicide determined		home, farm, si cify)	reet, factory, offic	28	28f. Location (City or To	Street and wn, State,	Number or	Rural Route Number,	
٥	Hospital of the source of the											
)	a Hospitai 24 hours a e Funeral I etely filled	cal	29a. Certifier Certifying P	hysician: To the best of my k miner: On the basis of exami	nowledge, dea	th occurred at the	time, date and place	a, and due to the	cause(s)	and manner	as stated. ue to the cause(s)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical	one)	and manner stated.								
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier				inse number				nth, Day, Year)	
•			1/11/11/			12	ES-000		NOVE	MBER	28,2007	
1	1		30. Name and address of person who									
			HELEN HUI-CHAI	GOO NORTH	MOLF	e stree	T BA	LTIMORE	MA	PRYLAN	0 21287	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	nette s						
	Regist	rar	UEC 0 3 20	Ul British	13	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	,	rtificate of Death		2007	38434
Physici	an	1. Decedent's Name (First, Middle, Last) Alice Esworthy				Day Year 2007	9:20 PM M
/Medic Examin	15%	4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Deat		4c. County of Death	
Examili	lei	College View Nursing		Frederick		Frederic	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last birthday, 75 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) Nov 11,	9. Birth Con 1932 Mary	nplace (State or Foreign untry) 1 land
yland now at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
a-fsl	ctor	MD Frederick	Freder				1 □Yes 2√2No
h with the	al Director	10e. Street and Number 609 Himes Avenue #10		10f. Zip Code 21703		Citizen of What Co USA	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. The file Trans 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	Ari	as Decedent Ever in U.S. ned Forces? 13. 13. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15	Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: W	e, etc. hite
within 72 horene. than "natur he Medical Is	Completed	15. Decedent's Education (Specify only highest grade complete in the complete	oleted) (Giv life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) alesperson		b. Kind of Business/	Industry un
filed Hygin	ပို	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Ma	iden Surname)	
ould be filed with Mental Hygiene. arked other than atic event, the Man	To Be	George Edward Gless	ner	Rosa Ma	y Durphey		
2 should I and Men Is marker aumatic		19a. Informant's Name/Relationship (Type. Pr		ling Address (Street and Number or F			
1 and 2 Health a em 27 Is		Connie Ahalt/daughte		Manhassett Farm			
permit. Pages 1 a Department of Hez mportant: If item sny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☒ Donation 5 ☐ Other (Specify)	ai ironi state	position (Name of ematory or other place)		c. Location - City or	
permit. Pages Department of Important: If is any injury or		21. Signature of Euneral Service Licensee Ronald S Wad	VID P	22. Name and Address of Facility State Anatomy Boar Baltimore, MD 212	01		
Physician		23a. Parth Enter the disease, or complication shock or heart failure. List only one cau immediate Cause (Final disease or condition	is that caused the death. Do not e use on each line. Discontage	nter the mode of dying, such as cardia	ac or respiratory arres		Approximate interval Between Onset and Death
/Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as a consequence of): Cevchro Vanla	1 Accident			YEARS
ficate be executed physician and is the burial-transit	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Chanca The Due to (or as a consequence of):	etwo Pulmonay	7 Direan	e	YEARS
ficate be e physician s the buri	edical	d					
death certii e attending d for use a	cian/M	in the past 12 months?		B Ectopic pregnancy Country Other (specify)		23d. Date of de Month	divery Day Year
law requires that the as been signed by the 2 should be detache	d by Physic	Part II. Other significant conditions contribu	ing to death but not resulting in the	underlying cause given in Part I.			o the cause of death? robably 4 □Unknown
The lay	Completed				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of s 2 400
cian: ertific ector,	Be (25. Was case referred medical examiner?	al:	Othori	eath Check onl one		
Physic r this o	မ	1 Yes 2 No Hospi 27. May er of Death 28	al: 1 Inpatient 2 ER/Outpat	ient 3 DOA 4 Nursing	Home 5 ☐ Resider		ecify)
ding I h. After funer	ion	Natural 5 Pending	(Month, Day Year) Injury			,,	
r Attenter deat	Certification:	Z Accident	le. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical Co			eath occurred at the time, date and pla r investigation, in my opinion, death o			
orthe omple	Mec	29b. Signature and the of certifier		29c. License number	29	d. Date signed (Mor	nth, Day, Year)
⊢ ≶ ⊢ ö				0006222	3	11/28/07	7
		29b. Signature and title of certifier 30. Name and address of person who completely a completely and the filed (Month, Day, Year) DEC 0 3 2007	eted cause of death (Item 23a) (Type	DLIVE FREDELI	CK. 70	-21702	
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Geneli			

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

salle.

30. Name and address of person who completed cause of death (Item 23a)

3

Ana Rubio MD. As 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

OCM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienea and All Copies Are Legible.

			For State Registrar		State 0	i iviai yiai		ertificat			i wentai r	Reg. I		38436
	Physici	an	1. Decedent's Name								2. Date of Month		Day Year	3. Time of Death
4	/Medi	cal	Richard 4a. Facility Name (II	frot institution ai		mher)		4h City	Town or	Location of De	Nove		4c. County of Deati	
	Examir	ier		s Commun		,		Lanl				- 1	Prince G	
	Funeral Director		5. Social Security N 561-26-29	957	Sex 1 M 2 □ F	7. Age (In yrs		Months	1 Year Days	If Under 24 H Hours Mi		Birth Day, Yes	9. Birti 922 Mass	hplace (State or Foreign untry) sachusetts
	land ow		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or	Location						10d. Inside City Limits
	a-f sh	ctor	MD	Prince	George'	s Mi	itche1	lville	!					1 □Yes 2√∑No
	or 28	Dire	10e. Street and Nur	mber				10f. Zip				10g.	Citizen of What Co	untry?
	s 23a nust t	eral		ottsford			10 14	0.14/		0721	/O		USA	ion Indian
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 1 □ Never Marri 3 □ Widowed		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2∏No ve		1 🗆 Yes	2 ∏ №	Specify:	(Specify Yes or erto Rican, etc.)			e, etc. Nite
15.6	"natı	lete		15. Decedent's E ify only highest gi	ade completed)		16a. De (G life	cedent's Usu ive kind of wo	al Occupa rk done de se retired)	ition <i>uring most of</i> v	vorking	16b	. Kind of Business/I	ndustry
7,7	within liene.	dwo	Elementary/Seco	ndary (0-12)	College (1	1-4or 5+)	""		physi				researc	h
A b	be filed tal Hygi d other event, tl	3e C	17. Father's Name (First, Middle, Las	t)	· · · · · · · · · · · · · · · · · · ·					lame (First, Mid	dle, Maio		
Zan	should b and Ments marked umatic e	2	Valenti	ne Mure	FitzHugh	1					Lizabet			
Mar	nd 2 sho Ith and 27 Is m		19a. Informant's Na Elisabe	ame/Relationship th FitzH		ıse							ty or Town, State, 2 chellvill	(ip Code) e, MD 20721
Fitzhugh, Richard Baltimore, Maryland 21215-0036	Pages 1 arment of Heamant: If Item			osition Cremation 3 [5 Other (Spec			Place of Dis cemetery, o	sposition (Nai crematory or o	ne of other place	e)	Date	20c.	Location - City or	Γown, State
Balt	permit. Departr Imports any Inji		21. Signature of Fu		Wade I	recto	r	22. Name a State Baltim	Anato	s of Facility Dmy Boa MD 21	rd 655	W. B	altimore	Street
			23a. Part1. Enter the shock, or hea	he disease, or cor rt failure. List only	nplications that o	aused the dea	ith. Do not	enter the mod	le of dying	, such as card	iac or respirator	y arrest,		Approximate Interval Between
-	Physician		Immediate Cause (disease or condition resulting in death)	Final	-	NEW								Onset and Death
	/Medical Examiner		resulting in death)	•	Due to	(or as a conse	quence of):							
restr	100	er	Sequentially list con	nditions, imediate	b. Due to	or as a conse	quence of):							7
	cuted nd ransit	Examiner	Sequentially list configure in leading to imcause. Enter Unde Cause (Disease or that initiated events	injury	c									h _
68760,	tificate be executed g physician and as the burial-transit	al Ex	resulting in death) L	ast	Due to (or as a conse	quence of):							
687	fficate g phys ts the	ledical	LL.		d									
.О. Вох	idan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		oirth 2 □ Fet nant at time of	tal death	3 □Ectopic p 5 □ Other <i>(s</i> į				_	23d. Date of deli Month	ivery Day Year
₽.	ires that signed b		Part II. Other signif		contributing to de			e underlying o	ause give	n in Part I.				the cause of death?
200	s been s been s should	letec	V / 1 - V	7 (, - 4				24a. W			topsy findings available
al Re		Completed by									p	utopsy erformed s 2	?// death?	completion of cause of 2□ No
Ę	Physician: r this certific ral director,	Be c	25. Was case reference examiner?		Hospital:		7.FD/0t		Otho	W4	eath Check or			
ō	g Phy er this eral di	<u>ان</u>	27. Manne Death	h	28a. Date	npatient 2 of Injury	28b. Tim	e of	8c. Injury	4 L Nursing			6 □Other (Specialist of the following occurred)	:ify)
io	ath. or: Aft	atio	1 ≝ Natural 2 ☐ Accident	5 Pending investigation	n	th, Day Year)	Inju	M	Work′ 1 □ Y	? ′es 2∐No				
Division or Vital Records,	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Flace	of injury - At h	nome, farm, ify)	street, factor	, office		28f. Locatio City or	n (Street Town, St	and Number or Ru ate)	ral Route Number,
	he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the miner: On the b and man	best of my kn asis of examin ner stated.	owledge, de ation and/o	eath occurred r investigation	at the tim , in my op	e, date and pla pinion, death o	ace, and due to ocurred at the til	the cause ne, date	e(s) and manner as and place, and due	stated. to the cause(s)
	With To t	Σ	29b. Signature and	title of certifier				29	c. License	number	51	29d.	Date signed (Month	ı, Day, Year)
			P VIET	U						201	<i>ا</i> ر		11/23/0	
			30. Name and addr	416	completed caus	e of death (Ite	m 23a) (Typ	De, Print)	AW	e R	were	Sali	2 JMP	20737
	Sta Regist		31. Date filed (Mon	th, Day, Year) DEC 0 3	2007 32.R	egistrar's Sign	ature	Carte						to the cause(s) h, Day, Year) 20737

1 - For State Registrar 1. Decedent's

Director

Be Completed by Funeral

2

Examiner

MILESH J.

PATER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

S. Siddle

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

F	Please Ty	•			delible Ir artment o			-		egible.	······································
For State		otate of	iviaryiaf	-	arımeni o <i>rtificate d</i>			nemai Hy	/giene Reg. No. '	200	7 201.27
Registrar 1. Decedent's Name (First,	Middle, Last)				- Innouto C) Dout		2. Date of De	eath	<u> </u>	3. Time of Death
DORIS A	NN GENIE	ΥY						DEC Month	Day	200	AM
4a. Facility Name (If not ins	-		_		4b. City, Tow	n, or Location	on of Death		4c. (County of D	Peath
	SPITAL		3ALTI		12010	rimer	der 24 Hrs.	CITY			n/a
5. Social Security Number	6. Sex	м 2/2 F	. Age (<i>In yrs</i> . 78	last birthday) Yrs.	If Under 1 Y	ays Hour		8. Date of Bi (Month, D	nn <i>ay, Year)</i> 24 ,1 929		Birthplace (State or Foreign Country) rvland
213-60-2119 Usual Residence of Decede		Λ	70					April 2	H, 1929	ria	Lylati
10a. State 10b. C	,	•		ty, Town or Lo							10d. Inside City Limits
Maryland Ba	1timore		B	altimore	,						1 □Yes 2X No
10e. Street and Number					10f. Zip Co				10g. Citiz	en of What	
6401 N. Charles		2. Was Deced	ant Ever in I	C 13		212	Origin? (Sn	acifu Ves or N	0- 1		J.S.A.
 Marital Status Never Married 2[Armed Ford	es?	.3.	Was Decedent If Yes, specify	Cuban, Mex	ican, Puerto	Rican, etc.)			Vhite, etc.
3 □ Widowed 4 □ Div		1 ☐ Yes 2 If Yes, Give Year or Dat	es:		1 ☐ Yes 2🏋	No Spec	sify:			Specify:	White
	cedent's Educa			16a. Dece	dent's Usual O	ccupation one during n	nost of work	ing	16b. Kin	d of Busine	ess/Industry
Elementary/Secondary (-	Colleg <u>e</u> (1-4	lor 5+)		kind of work do DO NOT use re nistrator			-	to a		
17. Father's Name (First, M	Aiddle Last)	т.		PCIIIC	Instrator		other's Name	e (First, Middle		catio	onal
William	madic, Eddiy		Centr	7				eanor 0'C		amamoj	
19a. Informant's Name/Re	lationship (Type	e. Print)		-	ng Address (St	reet and Nu	mber or Rur	ral Route Numi	ber, City or	Town, Stat	te, Zip Code)
Patricia Glink	a SSND	(Adm.)		6401	N.Charles	s Stree	t Balti	more,Mar	yland	21212	
20a. Method of Disposition				Place of Dispo	osition (Name o	of r place)		Date	20c. Loc	ation - City	or Town, State
1 XBurial 2 □ Crem 4 □ Donation 5 □ O		moval from Si		illa Mar	ia Cemete	ery	12-4	:- 07	Glen	Arm,M	aryland
21. Signature of Funeral S	ervice icense	e	,	2:	2. Name and A			hell—Wie 1 Baltimo			00047480
23a. Part1. Enter the dises	ase, or complic	ations that car	used the dea	th. Do not en	ter the mode of	dying, such	as cardiac	or respiratory	arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition		AC.	UTE		MORRA			ROKE			Onset and Death
resulting in death)	Ta.	Due to (o	r as a conse			-					
Sequentially list conditions	, b.			- 6							
cause. Enter Underlying Cause (Disease or injury	* *	Due to (o	r as a conse	quence of):							9
that initiated events resulting in death) Last	c.	Due to (o	r as a conse	quence of):							
		,		. ,							
	d.										
IF FEMALE: 23b. Was decedent pregning in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ant		th 2□Fet nt at time of	al death 3	⊒Ectopic pregn ⊒ Other <i>(specit</i>				2	3d. Date of Month	delivery Day Year
Part II. Other significant c	onditions cont	ributing to dea	th but not res	sulting in the u	ınderlyi n g caus	e given in Pa	art I.	23e. Did	tobacco us	se contribut	te to the cause of death?
HYPERT	ENSION	1, 0	nones	14 97	nteny c	11sew	مو	1	Yes 2]No 3[Probably 4x Unknown
				/				24a. Wa auto per	s an opsy formed?	prior d <u>ea</u> t	
25. Was case referred to r	nedical					26 P	ace of Dest	1□ Yes th (Check only	2 N O	10	Yes 2□ No
examiner? 1. 1 Yes 2 No	_	ospital: 1 🛂 In	patient 2]ER/Outpatie	nt 3 DOA	Other:		ome 5 ☐ Res		Other (Specify)
27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	28a. Date of (Month	Injury , <i>Day Year</i>)	28b. Time o Injury	of 28c.	Injury at Work? 1 Yes 2		28d. Describe		· ·	
3 ☐ Suicide 6 ☐	Could not be determined	28e. Place o building	of injury - At h	ome, farm, st	reet, factory, of	fice		28f. Location City or To	(Street and own, State)	l Number o	r Rural Route Number,
	ertifylng Physi edlcal Examin		sis of examin								er as stated. due to the cause(s)
29b. Signature and title of	certifier				29c. Li	cense numb	er		29d. Date	signed (M	fonth, Day, Year)
Nilein	Parte	1 m	P		P	6495	7		DEC	- 17	2007

To the Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Physician /Medical Examiner

State Registrar

SINAL

HOSPITAL OF BALTIMORE

07-09210	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Will	iam Patric	k G		ard I- For State Registrar	State	of Marylan	-	artment of ertificate of		nd Mental H		2 (007	3843
Me	Physi dical Exa		n/	Decedent's Name (First, Middle,Las		IAM P	ATRICK	GIGGA	RD	2. Date of Death Month November			Time of Death 1156 hrs
4500				4a. Facility Name (if n 2938 Baltimor		e street and numl	per)		4b. City, Town, o Finksburg	r Location of Death	1	4c. County of Carroll	Death	
	Funer Direct			5. Social Security Nur 218-84-6	4 -	x 7.	. Age (in yrs.	last birthday) 39 Yrs	If Under 1 Ye Months Da		_	1968	9. Birthpl Foreign Count	
	any		-	Usual Residence of D			10c. City	y, Town or Locat	ion				10	0d. Inside City Limits
	*	ice.		MD	CARROL	L		NKSBUR					1	Yes 2X No
	Maryla r 28a-f	ed at or	Director	10e. Street and Numb					10f. Zip Code		10	g. Citizen of Wha	it Country	?
	vith the	ust be notified at once.		2938 BA	ALTIMOR	E BLVD		J.S. 13. Wa	210	48 lispanic Origin? (S	pecify Yes or No-	USA 14. Race -	American	n Indian, Black,
_	death v	must be	Funeral	1 X Never Married		Armed Ford			es, specify Cuba	an, Mexican, Puerto		White,	etc. WHI	me
	irs after ural",	miner	اھ	3 Widowed 15. Decedent's Educ		If Yes, Give Year or Dates: nly highest grade	completed)	1 16a. Deceder	Yes 2 X N	o specify: ation (Give kind of	work done	Specify: 16b. Kind of Bus		
	6 72 hou an "nat	cal Exa	mpleted	Elementary/Second		College (1-4			ost of working lif	e. DO NOT use re		FLORIS	em.	
	5-0036 led within 7 Hygiene.	Medi	01	1 1 17. Father's Name (Fi	irst Middle Last			<u> </u>	J.	ORIVER	e (First, Middle, N			
	21215- ould be filed Mental Hy marked ot	ent, th	Be		W	ILLIAM	G. G:			DOR	S LOUI	SE BUC		
	MD 21 d 2 should lth and Me n 27 is ma	natic ev	_	19a. Informant's Nam			HER	4	- ,	eet and Number or		•		ip Code) D 21048
	e, M 1 and 2 Health item 2	r traun	- 1	20a. Method of Dispo	sition		20b		sition (Name of c		Date	20c. Location -		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she	or othe		4 Donation 5	Other Specify	Removal from	AL	L COUN	TY CRE	матіфи				
	Balt permit. Depart	injury		1. Signature of Fune	eral Service Licer	see				ss of Facility FL AIN ST.				OME, P.A.
	Physicia	_	7	23a. Part Enter the failure. List only	disease, or comp	lications that cau	ised the deat	th. Do not enter t	he mode of dying	g, such as cardiac	or respiratory arre	est, shock, or hea	rt MI	Approximate Interval Between Onset and
7	'Medic xamin	_		Immediate Cause (Fi	nal disease a.	Atherosc.			cular dis	Xasc			\rightarrow	Death
		ı		Sequentially list cond	h	`								
			Examiner	if any, leading to imm cause. Enter Underly (Disease or injury that	ying Cause	Due to (or as a c	onsequence	of):						
	P T	ansit		events resulting in de		Due to (or as a c	onsequence	of):						
	e be executed	ourial - transit	edical	X UNPENDED		AMENDED #23a . 27	.nerME.g	2874. 12/6	5/07 TT					
	68760 certificate I	as the bu	žΙ	IF FEMALE: 23b. Was decedent pr	egnant in the	23c. If yes, ou	accome of pre	griancy	etal death 3	Ectopic pregr	ancy	23d. Date of of Month	delivery Day	y Year
	Box 6 death cert	for use	Sic	past 12 months?	9 Unknow	,	nt at time of o	donth -	ther (Specify)					
	Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy	ector, page 2 should be detached for use as the burial - trai		Part II. Other signific	ant conditions			resulting in the	underlying cause	given in Part I.	23e. Did to			e cause of death?
	S, P.	ld be de	ed by			· · · · · · · · · · · · · · · · · · ·					1 Yes	- C	1	bly 4 Unknown psy findings available
	Cord law rec has bee	2 shou	Completed				·				autop perfor	sy p med? d	rior to con eath?	npletion of cause of
	of Vital Records, ng Physician: The law requir After this certificate has been s	director, page		25. Was case referre	d to medical				26.Pla	ce of Death (Check	1 Yes	2 No 1	✓ Yes	2 No
	of Vita ing Physicia After this ce	ŧ	To Be	examiner? 1 ✓ Yes 2	No		patient 2	ER/Outpatien				Residence 6	-	Scene
	on of nding F th.	e funeral		27. Manner of Death 1 X Natural	5 Pending	28a. Date o (Month, I	f Injury Day,Year)	28b. Time of		jury at Work? Yes 2 No	28d. Describe i	now injury occurre)d	
	Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A	completely filled in by the	ertification:	2 Accident 3 Suicide	Investigat Could not	28e Place	of Injury - At	home, farm, stre	et, factory, office	e building, etc.	28f. Location (S or Town, S		r or Rura	I Route Number, City
	Ospital hours a	y filled	O F	4 Homicide	determine	1 (0,000)/								
	o the II ithin 24 o the Fq	mpletel	edical	(Check only			examination			date and place, an on, death occurred				
4	F 3 F	3	ğ	29b. Signature and til	tle of certifier					nse number		29d. Date signe		
			-	30. Name and address	as of person who	completed cause		em 23a)	0.0	C.M.E.		November :		
	0		_	Ling Li, MD	Assistant M	ledical Exam	iner 11	1 Penn Stre	et, Baltimore	e, MD 21201				
	Reg	Sta	-	31. Date filed (Month)	Day, Year) 0 3 200		istrar's Signa	ature /	K)					
	HMH 17 Rev					DOME		ORIGINA	\L					

07-09124 Elias Greene

lias Greene		State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 2007 3843									
Physician/	/ 1	. Decedent's Name (First, Middle,Last)					2. Date of Dea	ath	3. Time of Death 1526 hrs		
Medical Examiner	ш.	Elias Green a. Facility Name (if not institution, give street and number)	- 14	h City T	own orlo	ocation of Dea		Day Year er 25, 2007 4c. County of Dea			
		7301 Calder Drive			ol Heigh			Prince Georg	ge's		
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last bit	thday)	If Unde	er 1 Year	If Under 24H	Irs. 8. Date of Bi	irth (MM/DD/YYYY) 9. I	einn		
Director	Ŀ	577-56-0446 _{1X M 2} F 67	Yrs.	Month	s Days	Hours	Oct.		CountrWash.D.C.		
á	_	Java Residence of Decedent	or Location	on					10d. Inside City Limits		
nd show a	_	MD Prince Georges C	apit	al	Heig	hts			1 X Yes 2 No		
the Maryland n or 28a-f show any tified at once. Director		0e. Street and Number		10f. Zip	Code			10g. Citizen of What C	ountry?		
with the Maryland ns 23a or 28a-f sho be notified at once. eral Director		7301 Calder Drive	Lioni	5	207		Caralle Van an N	U.S.A.	nerican Indian, Black,		
r death with or items 23 must be no	1	1. Marital Status					Specify Yes or N rto Rican, etc.)	White, etc			
fter de l'', or il		1 Yes 2 X No 3 Widowed 4 XDivorced If Yes, Give Year or Dates:	1 🗌	Yes 2	X No	specify:		Specify: E	Black		
hours aft natural" Examine		15. Decedent's Education (Specify only highest grade completed) 16a				n (Give kind o		16b. Kind of Busines	ss/Industry		
36 nin 721 than "; dical.H	blet	Elementary/Secondary (0-12) College (1-4 or 5+)	Me	edic	al	Tech		privat	٠_		
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner Completed by	5	17. Father's Name (First, Middle, Last)		2410			me (First, Middle	, Maiden Surname)			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than it event, the Medical To Be Comple	å L	Saul Green 19a. Informant's Name/Relationship (Type, Print)	Ob. 8.4-10:		(0)	and Mountain	Minni	e Willia umber, City or Town, St			
O ≝ B : # # .	(Total international control of the c			`			d, MD. 2072			
e, N 1 and 2 Health item 2		20a. Method of Disposition 20b. Place		ition (Nar	ne of cem		Date	20c. Location - City			
MOF Pages tent of unt: 1f	- 1	1 X Burial 2 Cremation 3 Removal from State Fort	Lin	col	n Ce	em. 12	1-1-07	Brentwo	ood, MD		
Baltimore, MI permit Pages I and 2s Department of Health a Important: If item 27 injury or other traum		21. Signature of Funeral Service Licensee Francis B. Hunt Francis B. Hint			Address Fun.		908 Ke	nnesday S	DC 20011 St.NW.Wash.		
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.		ne mode	of dying, s	uch as cardia	c or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and		
'Medical .xaminer		Immediate Cause (Final disease a. Multiple Stab and Cutting V	Vounds						Death		
	- 1	h									
ner	힐	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Causs									
ted Insit Examiner	E	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):									
ecuted and trans	ᇎ	d,									
50, te be executed ysician and burial - transit	ğ	IF FEMALE: 23c. If yes, outcome of pregnance						23d. Date of deli	very		
b. Box 6876 the death certificate by the attending phy ched for use as the beath	an/s	23b. Was decedent pregnant in the	2 Fe	tal death	-	Ectopic pre	gnancy	Month	Day Year		
Sox leath or e attent for us	ysici	4 Pregnant at time of death 1 Yes 2 No 9 Unknown g Unknown	5 Ot	her (Spe	ecify)						
ines that the de signed by the signed by the signed by the signed by the signed by the signed of the signed by Phy		Part II. Other significant conditions contributing to death but not result	ing in the ι	underlyin	g cause gi	ven in Part I.			e to the cause of death?		
S, P. uires th n signe d be d	ed by					·-··	1Y 		Probably 4 Unknown e autopsy findings available		
cords, law requin	틢						aut		to completion of cause of		
tal Records, Itian: The law requires certificate has been signed, page 2 should be Completed	5				00 Di	of Death (Che	1 ✔ Yes		Yes 2 No		
fital sician;	mĭ۱	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER	Outpatient	3		Othor:	rsing Home 5	Residence 6 🗸 C	Other: Scene		
of Ving Physical After this uneral direction.		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	. Time of I	Injury	28c. Injur	y at Work?		e how injury occurred abbed and cut			
sion ttendi death. ctor: /	읥	2 Accident Investigation	24 hrs			es 2 V No			- David Nambar City		
Divis alor A safter al Dire	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family		et, factor	y, office bi	uilding, etc.		i (Street and Number o i, State) ir Drive, Capitol Heig	r Rural Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transited in the funeral Contribution. To Be Completed by Physician/Medical Expedical Control of the contribution of the completed by Physician/Medical Expedical Control of the control of	깕	29a. Certifier 1 Certifying Physician: To the best of my knowledge, c	leath occu	rred at th	e time, da	te and place,	and due to the ca	ause(s) and manner as	stated.		
Fo the vithin 2 fo the Jonnplet	Medical	one) 2 Medical Examiner On the basis of examination and/o	r investiga	tion, in π	ny opinion,	death occurr	ed at the time, da	te and place, and due	to the cause(s)		
A T	ž	29b. Signature and title of certifier		29	C. License			29d. Date signed November 26	(Month, Day, Year)		
31					O.C.N	VI.C.		140Veniber 20	, 2007		
OCME		 Name and doress of person who completed cause of death (Item 23a Mary G/Ripple MD. Deputy Chief Medical Examin 	er 11	1 Penr	Street,	Baltimore	e, MD 21201				
Stat	te	31. Date filed (Month, Par, Year) 3 200 732. Registrar's Signature	F. 6	2006			-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4 of Maryland / Bepartment of Realth and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 17 OCTOBER 2007 04:30 A Charles Hicklin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Leonard Town St. Marys Hospital St. Mary's

9. Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 3/13/52 1 X M 2 □ F 55 223-76-6310 S.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County 28a-f show a or 28a-f show t be notified at Director X⊓Yes 2∏No GreatMills Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20634 items 23a c U.S.A. 22060 Mojava Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 'natural", or Specify Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry artment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than ' injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Dept Laborer 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Hicklin Baker Thomas Guyton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Barbara Hicklin 22060 Mojava Dr. Greatmills Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/23/07 1

Burial 2 □ Cremation 3 □ Removal from State Suffolk, Va Suffolk Albert G, Horton 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Carlos A. HowardFuneralHome
436W.35thStreetNflk, Va23508 21. Signatu of Fin Lynnoc Againstrong Patterson

per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Myocarda **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diaticase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of) Examiner Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ► R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

CHANDRA SAJJA MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

506-ab-4

0 DEC

HOLLYWOOD MARYLAND 32 Hagistrar's Signature

20636

CHARLES HICKLIN

29c. License number

D54346

29d. Date signed (Month, Day, Year)

10/17/07

07-09 Mary Medi

)241 Jo Hartlove		Please Type or Print in										
Jo martiove		State of Marylan	· · · · · · · · · · · · · · · · · · ·	e of Death	u Mentai ny	rgierie Reg.	200	7 3844				
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death				
ical Examii			RTLOVE			Month November 2		1230 hrs				
		4a. Facility Name (if not institution, give street and number 1985 Poplar Ridge Road	per)	4b. City, Town, or Pasadena	Location of Death		4c. County of Death Anne Arundel					
Funeral			Age (In yrs. last birthd		ar If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Birl					
Director		215-70-1132 1_M 2KF	51	Yrs. Months Day	s Hours Min.	Sept. 1	5,1956 Foreig	n untry) Maryland				
		Usual Residence of Decedent						10d. Inside City Limits				
ow any		10a. State 10b. County Maryland Anne Arundel	10c. City, Town or	adena				1 Yes 2 No				
ryland a-f sh	ctor	10e. Street and Number	1 436	10f. Zip Code		10g	. Citizen of What Cour	ntry?				
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r death or ite	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Deced Armed Force 1 Yes	2 No			110011, 0101)	Specify: Who	ite				
urs afte	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade		1 Yes 2 No		vork done 1	6b. Kind of Business/	Industry				
72 hou n "nat	etec	Elementary/Secondary (0-12) College (1-4	du	ring most of working life		red)	П.,					
Vithin iene.	Completed	12 0		Homemake		(Flora Middle Ma	Home					
filed al Hyg	Be Co	17. Father's Name (First, Middle, Last) Charles Bouchard			18.Mother's Name		ovenza					
212 212 212 213 213 214 215 215 215 215 215 215 215 215 215 215	To B	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stre	et and Number or F	Rural Route Numb	er, City or Town, State	, Zip Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		John W. Hartlove (Husba		985 Poplar								
or Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	State cremator	Disposition (Name of ce			20c.Location-City or Baltimore,					
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Sox 68760, death certificate be enterested attending physicial for use as the buriant.	Physician/Med	23b. Was decedent pregnant in the past 12 months?	2	Fetal death 3	Ectopic pregna	ancy		Day Year				
Box 6 e death ce the attend led for use	sici	1 Yes 2 No 9 V Unknown g Unknow	nt at time of death 5	Other (Specify)								
O. B at the d d by the		Part II. Other significant conditions contributing to a		in the underlying cause	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?				
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Divisior spital or Attenctours after death neral Director: filled in by the	Certification:	3 X Suicide 6 Could not be	of Injury - At home, farr	m, street, factory, office	building, etc.	28f. Location (St or Town, Sta		ural Route Number, City				
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To Wit To	Мес	and manner sta 29b. Signature and title of certifier	29d. Date signed (Mo									
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$\sqrt{}$		30. Name and address of person who completed cause		enn Street, Baltim	ore MD 2120	1						
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harles David H		nson St - For State	ate of Maryla	and / Depart	ment of	k. Ensure All Copies Are Legible. Health and Mental Hygiene Death Reg. No.						20	07 3	ΩI.
Physicia	R	tegistrar 1. Decedent's Name (First, Midd	e,Last)		ilcale of	Dealli			2.	. Date of De Month Novemb	eath		3. Time of Death	n 4
Aedical Exami		Charles Donald	Hutchinson	30n		,				Novemb	er 1,	4c. County of Deat		
		4a. Facility Name (if not institution 1209 Walnut Road	on, give street and n	umber)	4	b. City, To Delmar		ocation of				Wicomico		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under	1 Year Days	If Under	24Hrs.	8. Date of	Birth(N	M/DD/YYYY) 9. Bii Forei	an	
Director		216-02-8308	1X M 2 F	41	Yrs.	Montris	Days	Flours	IVIII I.	Ju1y	30,	, 1966 ^{Co}	ountry Mary 1	<u>and</u>
Ç î	_ <u>_</u>	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Locati	on					10d. Inside			Limits
			mico		Delmar								1 Yes 2	X No
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	, m200			10f. Zip C					10g.	Citizen of What Cou	intry?	
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212 ould bould by a Ment s mark	악	19a. Informant's Name/Relation	ship (Type, Print)									r, City or Town, Stat	e, Zip Code)	
MD id 2 sh ilith and in 27 is		Karen Hutchin	son/spous	e I ann Pi	1209 lace of Dispos				Deli	mar, l	MD 2	21875 Oc. Location - City of	or Town, State	
or Heal		20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal	from State Cr	ematory or ot	her place)	o con	iotory,						
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Physician		23a. Part I. Enter the dise se, of fure. List only one caus	or complications that	caused the death.	Do not enter t	he mode o	dying,	such as c	ardiac or	respiratory	arrest	, shock, or heart	Approximate Between On	set and
Medical aminer		Immediate Cause (Final diseas	e a Contac	t gunshot w	ound to	head							Deati	1
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Box 68760, e death certificate be execut the attending physician and ced for use as the burial - trai	sician/Medica	IF FEMALE: 23b. Was decedent pregnant in	23c. If ye	s, outcome of pregr e birth	nancy	etal death	3	-	ic pregna	ncy		23d. Date of delive Month	-	'ear
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of \ of \ ng Ph;	Ë	27. Manner of Death	28a. D	ate of injury onth, Day,Year)	28b. Time of	Injury		iry at Wor		28d. Desc	ribe ho	w injury occurred		
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Division of Vital Records, tal or Attending Physician: The law requirers after death. Director: After this certificate has been siled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	Certification:		ould not be termined 28e. F	ifu) -		rm, street, factory, office building, etc. 28f. Location (Street and North Properties) 28f. Location (Street					ate) rt Rd. Delma	r. MD	,	
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		30. Name and address of personal Zabiullah Ali, M.D.	on who completed o	cause of Geath (Item dical Examiner	123a) 111 Pe	enn Stre	et, Bal	timore.	MD 21	201				
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Regi	State	nr e		Bearing 1	OF AL	124/2	,					OCME		

Registrar

Registrar DHMH 17 Rev 1/2001

State

BAITIMORE,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

4920 Campbel

DEC 03

31. Date liled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 38444 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Hershfield Sanford November 07:00 27 2550 7 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min 143-14-6360 3 1920 Director NJ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City_Limits 1 es 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates 1 Never Married 2 Married 2 7 N Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hershfiel Harr Anna exlandt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 Is any Injury or other trau 800 mD 21286 alre lowson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) tro Crementery 12-7 21. Signature of Service Licensee 23a. Part1. Enter it shock, or hea the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory art failure. List only one cause on each line. Immediate Carre (Final disease or condition resulting in death) Conjestive heart failure **Physician** 10ckings /Medical Due to (or as a consequence of): Examiner Myocardial infarction Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 11 CKuis Due to (or as a consequence or): Examiner be executed Coronary artery disease 30 years and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy perform 2 X No Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours a To the Funeral I the Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 3 2007

Anupama Gupta, The Johns Hopkins Hospital, 600 North Wrife Street, Baltimure, Maryland, 21287 32. egistrar's Signature Stille

▶ Anupama Gupta, Medical Ductor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

November 27, 2007

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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 Per FH G875 THE 28 Yer | Department of Health and Mental Hygiene 1- State Amend #23b Per Phy G874 12/69/19/2021 of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Wanda L. Hunt 11:00 November 2007 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | Separate of Birth | Months | Days | Hours | Min. | Min. | NOV | 15, 1954 Johns Hopkins Bayview Medical Center N/A 6. Sex Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F 212-60-7586 53 **Director** MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 28a-f show 10d. Inside City Limits must be notified at Director MD BALTIMORE 1 X Yes 2 ☐ No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important: If them 27 is marked other than "--- any injury or other traumant." 23a or 5068 OVRILLE AVENUE 21205 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOWARD AMBROSE MARGARET DUERBECK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENEE PISANI/ DAUGHTER 1433 BONSAL STREET, BALTIMORE, MARYLAND 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) LAWN CEMETERY 11/29/2007 BALTIMORE, MARYLAND Name and Address of Facility
ILLY & ZEILER INC. FUNERAL HOME
901 EASTERN AVENUE, BALTIMORE, MD. 21. Signature of Funeral Service Licenses 7901 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician failure respiratory disease or condition resulting in death) /Medical Due to (or as a consequenf): Examiner Myocardial Sequentially list conditions, if any, leading to financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Infarction Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery atter for u 3 □ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown P.O. I 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 a certificate 1∏ Yes 2 X No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day s after dea...ral Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a

To the Funeral I Mix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 November 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRANT CHOW MD. 4940 EASTERN AVENUE BALTIMORE, MD 21224

Registrar

State

31. Date filed (Month, Day, Year)

NOV 2 8 2007

DHMH 17 Rev 1/2001

🌠. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 11 per inf 9876 2-15-08 yr
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 4a. Facility Name (If not institution, give street and number) Jones NOV 28 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN GOOD HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 577-46-247 1 □ M 2 🔽 Director 2-6-1934 NC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 Pres 2 □ No Directo Baltimore 10e. Street and Number 10g. Citizen of What Country? 21239 Hameda Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Harried 2 Married 1 ☐ Yes 2 Z No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Hospita permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, ±1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) Unown ပ္ 19a. Informant's Name/Relationship (Type. Print) Janet Alford/Daugnter Alameda Balt, more, MI) 21239

20c. Location - City or Town, State The 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Cemetery 12.5 2001 Danie 22. Name and Address of Facility Varann C. Greene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mu 4905 York Proad Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician STROKE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ MELLITUS HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mulinown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy perform Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ² 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 NOV 28 2007

Registrar

DHMH 17 Rev 1/2001

SHAIKH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE

MD21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

31. Date filed (Month, Day, Year)
DEC 0 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 03:15 A M 23 2007 Phillip Johnson E 4a. Facility Name (If not institution, give street and number) Nov /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memoria Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □M 2 □ F Months Days Hours Min. 6.25.1946 Maryland 212-48-0833 Director 6 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number alalb Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 ■ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ZHO Specify Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Medical Lab iath Maintenace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental Pauline Johnson Thomas Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1727 E. 33rd Street Baltimore, MD 21218 Josie C. Johnson /c 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Porial 2 ☐ Cremation 3 ☐ Removal from State 11.29.2007 Baltimore, MD King Memorica Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Voughn C Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York Ad Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 12 days **Physician** disease or condition resulting in death) Intra cerebral /Medical Due to (or as a consequence of) Examiner Din Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HTN burial-tran to the Hospital or Attending Physician: The law requires that the death certificate be executive the Funeral Director: After this certificate has how to the Funeral Director: After this certificate has how the funeral Director. After this certificate has how the funeral Director in the funeral Director in the funeral Director in the funeral Director in the function of the functio Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes > No 2 ER/Outpatient 1X Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AT 2438946-HZ 23, 2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baroni D.O. Memorial Mouthon S. MD Union Hospital 31. Date filed (Month, Day, Year)
DEC 0 3 32 Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day DIVAC JONES 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE BALTIMORE CIT BALTIMORE MD If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-38-5285 Days 1X M 2□ F Hours 64 Director 8, 1942 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iteπs 23a or 28a-f show ner must be notified at MD Baltimore Windsor Mill 1 ☐ Yes ŽINo Director 10e. Street and Number 2628 Camberwell Ct. permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28 any injury or other traumatic event, the Medical Examination once. 10f. Zip Code 10g. Citizen of What Country? 21244 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1. XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Black ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Excrusion Mechanic Headwind Plastic Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Jones Luvinia Knox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalinda Jones/ Wife 2628 Camberwell Ct. Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/3/0 Pate 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Euneral Service License 5240 Reisterstown Rd. Baltimore, MD21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death In mediate Cause (Final disease or condition resulting in death) Ventricular tibrillation Physician minutes /Medical Due to (or as a consequence of): Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): severe arema Due to (or as a consequence of): O. Box 68760 attending physician for use as the buria abdomina compartment SVAdrome Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital-Record WONIC 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To complete, filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) after death. I Director: After ti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 To the Hospital or within 24 ours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the control of the cause of examiners. Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435B17559 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL B. BREWER, SURGERY DEPT. BALTIMORE, MD 21201 MD 22 S. GREENE ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2007 Month TOHNSON **Physician** NOVEYSE - VI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAU MANUALLITE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 919 Strawite of Vorthiert 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Months Maryland 1 □ M 2 🔽 F 88 Director 212-18-8204 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at N/A Baltimore MD XXYes 2 No Director 10f. Zip Code 21215 10e. Street and Number 2634 Quantico Avenue 10g. Citizen of What Country? Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Gundy 17. Father's Name (First, Middle, Last) Augustus Johnson 19a. Informant's Name/Relationship (Type. Print)
Ruby Sanuel/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2634 Quantico Avenue Baltimore, MD 21215 Injury or other Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 12/3/07 20c. Location - City or Town, State 20a. Method of Disposition XIXBurial 2 Cremation 3 Removal from State Lansdowne, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee Harris MD 21215 5240 Reisterstown Rd. Baltimore, owy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine Physician: The law requires that the death certificate be executed bunel-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. P.O. Division or Vital Records, or Attending

after death.

i Director: Af
d in by the fu To the Hospital within 24 hours at To the Funerei

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 27, ZOO

ALTO. MD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Medical

31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a Certifier

DEC 0 3



NHC,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

	1- For State 1- For State Registrar Certificate of Death Reg. No. 20										
Physician Medical Examine	1. Decedent's Name (First, Middler CURTIS	e,Last) S. L. JOHNSON				2. Date of Deat Month November		3. Time of Death 1351 hrs			
	4a. Facility Name (if not institution Union Memorial Hosp		-	4b. City, Town, o	r Location of Dea		4c. County of Oear				
Funeral	Social Security Number		(In yrs. last birth		ar If Under 24h	Hrs. 8. Date of Bir	N/A	rthplace (State or			
Director	520-64-4951	1 X M 2 F	54	Yrs. Months Da	ys Hours N	Sept 4	, 1953 Fore	^{gn} ^{ountry)} Montana			
v any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits			
ryland a-f short	Maryland 10e. Street and Number	N/A	Bal	timore		14	ng. Citizen of What Co	1 X Yes 2 No			
th the Maryland 23a or 28a-f sho notified at once	2623 Guilford	l Avenue		· ·	21218	["	USA	and y :			
D 21215-0036 Should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	11. Marital Status 1 X Never Married 2 Ma	12. Was Decedent Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	ispanic Ongin? (in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,			
after de	3 Widowed 4 Div	orced If Yes, Give Year	X No	1 Yes 2 X N	o specify:		Specify: V	Mhite			
12 hours "naturel Exam				Decedent's Usual Occupa Juring most of working life			16b. Kind of Business	/Industry			
15-0036 The within 7 Hygiene. d other than	Elementary/Secondary (0-12) 17. Father's Name (First, Middle,	3	Cle	erical Staf			Legal				
21215-0036 uld be filed within 72 Mental Hygiene. marked other than e event, the Medical						me (First, Middle, N a Eyaughn	Maiden Sumame) Harrelson				
MD 21 nd 2 should alth and Mer m 27 is mar armatic ev	19a. Informant's Name/Relations Mr. & Mrs. Ger	hip (Type, Print) Par	ents 196	. Mailing Address (Stree P.O. Box 11	et and Number o	or Rural Route Num	ber, City or Town, Stat	e, Zip Code)			
e, M and 2 fealth frem 2 traur	20a. Method of Disposition	3 Removal from Sta	20b. Place of	f Disposition (Name of corry or other place)		Date Date	20c. Location - City of	r Town, State			
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr	4 Donation 5 Other Sp	pecify:	Green	Mount Cemet		2/4/2007	Baltimore	, Maryland			
Bal permi Depar Impo injur	21. Signitur uner service Martin D. Laws 23a. Part I. Enter the disease, or	Licensee	WIEDEFEI Road F	D funera	1 home, in	21212					
Physician /Medical	23a. Part I. Enter the disease, or failure. List only one cause	complications that caused on each line.	the death. Do not	enter the mode of dying	, such as cardia	c or respiratory arre	est, shock, or heart	Between Onset and			
xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Attended or Due to (or as a conse		iovascular dis	case			Death			
i	Sequentially list conditions, if any, leading to immediate	b	quence of):								
ted Insit	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):								
xecuted n and l - transi		¬ d									
760, icate be executed physician and the burial - transit	X UNPENDED IF FEMALE:	23c. If yes, outcom	permE,G87 e of pregnancy	5, 1/8/08 TT			23d. Date of delive	ry			
Box 687 e death certific the attending to d for use as the	23b. Was decedent pregnant in the past 12 months?	I Live Ditti	ime of death 5	Fetal death 3 Other (Specify)	Ectopic preg	gnancy	Month	Day Year			
P.O. Box 68: that the death certifined by the attending detached for use as it they physician.	Part II. Other significant conditi	nown g Unknown		in the underlying cause	sives is Bort I	220 Didto	bacco use contribute to	o the source of death?			
S 60 60	_	Contributing to death	but not resulting	in the underlying cause	given in Fait i.	4-4-4-4		bably 4 V Unknown			
Division of Vital Records, P. (Ital or Attending Physician: The law requires the stra after death. al Director: After this certificate has been signed led in by the funeral director, page 2 should be det artification: To Be Commisted by						24a. Was autop	sy prior to	utopsy findings available completion of cause of			
of Vital Records ing Physician: The law requester this certificate has been uneral director, page 2 should not To Be Commilete				26 Dina	o of Dooth (Cho	1 Yes	med? death?	es 2 No			
Vital Physician: r this certifi al director,	examiner?	Hospital: 1 Inpatier	nt 2 🗸 ER/Ou		e of Death (Che Other: Nur		Residence 6 Oth	er;			
on of anding Ph. r: After to the funeral ion: T	1 27 Manner of Death	28a. Date of Injur (Month, Day,Ye	y 28b. T		ury at Work? Yes 2 No	28d. Describe h	now injury occurred				
Division o spital or Attending nours after death. neral Director: After filled in by the function:	2 Accident Inves 3 Suicide 6 Could	tigation 28e. Place of Injuri	ury - At home, far	m, street, factory, office		28f. Location (S or Town, S		ural Route Number, City			
Divi		mined (Specify) ysician: To the best of my	knowledge deal	th accurred at the time of	toto and place.	7		tod			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	(Check only one) 2 Medical Exam	niner: On the basis of exam and manner stated.					1 /				
ž		Dincerty, M.D.		29c. Licen	se number		29d. Date signed (M November 30, 2				
Jund 1	30. Name and address of person	who completed cause of de	•								
State	Donna M. Vincenti, M. 31. Date filed (Month, Day, Year)	Assistant Medica	s Signature	111 Penn Street	t, Baltimore,	MD 21201					
Registra		63	. 15 1	Coaste							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item 23a per dr., g874, 12/03/2020 Death Reg. No. 2 0 0 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Michelle Andrea Johnson November 9,2007 8:50 A **Physician** /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9506 Perry Hall Blvd. #101 Perry Hall Baltimore 8. Date of Birth (Month, Day, Ye May 10, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Year) 1967 Maryland **Funeral** Days Min. Hours 1 □ M **2/□X** 216-88-0456 40 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Baltimore MD Perry Hall 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9506 Perry Hall Blvd. #101 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) al Hygiene. 4 College (1-4or 5+) Office Manager Creative Options 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be George Johnson Pamela Haywood 2 19a. Informant's Name/Relationship (Type. Print)
Pamela Johnson/ mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9506 Perry Hall Blvd. #101 Perry Hall, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Rest Cemetery Towson, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 4210 Belair Road Baltimore, MD 21206 arro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZCILA disease or condition resulting in death) 17 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or 1, july that initiated events Due to (or as a consequence of): Examiner be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending plant IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 (No the detached 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown evidio my o palky Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1□ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DCA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 | Yes 2 | **** 2 this After this funeral of 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Attending (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attend within 24 hours after death To the Funeral Director: within 24 hours at To the Funeral C completely filled i

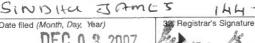
State Registrar

31. Date filed (Month, Day, Year) DEC 0 3 2007

29b. Signature and title of certifier

nollin.

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)



emes

IAHT YORK ROAD.

mo

29c. License number

100052292

29d. Date signed (Month, Day, Year)

LUTHETLUILLE

11/13/2007

MI) 21013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Jones 2001 M Katie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ba timor If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days Hours Min. Months 1 □ M 2**X** F 249-46-8344 79 12-10-1927 S.C. Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County Elliott 1 ¥ Yes 2 □ No Baltimore Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3201 The Oaks Rd. 21043 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: Black \$ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sheppard Pratt Elementary/Secondary (0-12) 8th grade College (1-4or 5+) Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nae Rosa Askins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3201 The Oaks Rd., Elliott City, Md. Lula Askins Johnson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Timonium, Md. 12-3-07 Dulaney Valley Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East lady 1101 E. North Ave., Baltimore, Md. 21202 wane Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. mos of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) dours Physician /Medical Due to or s a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a con P.O. Box 68760. Physician/Medical F FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performedy Yes 2 No 2 No 1 ☐ Yes 1☐ Yes **Division or Vital** or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: 1 hpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 🗌 Yes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Mate of Injury 28c. Injury at Work? (Month, Day Year) 1 Natural ∠ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. the within To the 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 26, Month **Physician** 2007 7:45 AM Novmeber Kolk Linda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Dundalk 119 Briarwood Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 T F Months Days Hours Min. Director 219-58-2341 58 19,1949 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2 No Maryland Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 119 Briarwood Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int; If Item 27 is marked other than "natural", or Ite 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 9 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard E. Shock Frances Lumpkin Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 21222 119 Briarwood Road permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Mr. Victor E. Kolk, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) Evergreen Mem. Cem. 11/30/2007 Finksburg, Maryland 4 ☐ Donation 2. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of 7922 Wise Ave. Dundalk, Maryland 21222 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ vascular diseise Completed melletus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy certificate ha Hypertension 2 1 No 1□ Yes or Attending Physician: director, 25. Was case referred to r examiner? 26. Place of Death (Check only one) Be Other: 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5☐Residence 6 ☐Other (Specify) Certification: To 2 No 1 ☐ Inpatient this s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af To the Funeral D completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier acd attaraow MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) death (Hem 23a) (Type, Print) 9114 Philadelphia Road Saite 108, Balt, Md. 2123 ATTANABO MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 0 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Rodney G. Kemp

4a. Facility Name (If not fassilution, give street and number) DH /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA altimore Maryland Medical Whitersitu OF Center 8. Date of Birth (Month, Day, Year) May 9, 195 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1**2** M 2□ F Hours 51 214-72-0792 1956 Michigan Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Glen Burnie Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 123 5th Avenue S.W. 21060 Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: 3altimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Company Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dalton Dolores Ι. Gene ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4408 Donna Drive, Pasadena, Maryland 21122 Dolores J. Decker (mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 12-03-07 Baltimore, Maryland Bayview Crematory 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death munediate Cause (Final disease or condition resulting in death) caccinoma oral iamous (Ell **Physician** /Medical Due to or as a consequence of): Bacteremi **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown After this certificate has been signed by i funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 3□ DOA Certification: To 1 ☐ Yes 1. Inpatient 2 ER/Outpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fi Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 State

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

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ards

32 Registrar's Signature

Boltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09138 2007 38456 State of Maryland / Department of Health and Mental Hygiene George Steve Kusick, III Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1051 hrs November 26, 2007 ' Examiner Mer STEVE KUSICK **GEORGE** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 614 Annabel Avenue 9. Birthplace (State or 8. Date of Birth (MM/DD/YYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Foreiar **Funeral** Months Davs Hours Min Country) Maryland Jan. 30.1969 38 Director 215-06-2045 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No N/A Brooklyn 28a-f show Maryland Jeath with the Maryland 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Numbe U.S.A. 21225 614 Annabel Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Armed Forces? 1 Never Married 2 1 X Yes _{Specify}White 2 Itimore, MD 21215-0036
tir. Pages I and 2 should be filed within 72 hours after dea
trans of Health and Mental Hygiene
ortant: If item 27 is marked other than "natural", or it
yor other traumatic event, the Medical Examiner mus Yes 2 X No specify: Divorced If Yes, Give Year Kind of Business/Industry 3 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Home Improvements Self-Employed 12 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Janet Arthur Geroge S. Kusick Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ۵ Brooklyn Park, Maryland Baltimore, MD 113 West 5th Avenue. Geroge S. Kusick Jr. (Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12-01-07 Glen Burnie,Maryland Glen Haven Mem Park Department of Important: injury or other 4 Donation 5 Other Specify ²². Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Euneral Service Licensee 237 Fast Patapsco Ave Baltimore of Heart and Length of the Baltimore of Heart and Length of the Baltimore of Heart and Length of the Baltimore of Heart and Length of Approximate Interval Between Onset and hysician failure. List only one cause on each line Death ledical Morphine and cocaine intoxication Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED #250a,27,28a-f, perME, g874, 12/11/07 TT attending physician or use as the burial The law requires that the death certificate be 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death led by the attending detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy death? performed? has 2 No 1 🗸 Yes ✓ Yes 2 certificate h 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene examiner? FR/Outpatient 3 DOA Inpatient 2 this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After Certification: Yes 2 xNo Natural unk. Pending Fnd 11/26/2007 Fnd 10:30 am Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 614 Annabel X Could not be determined 24 hours after 3 Suicide (Specify) found at residence the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 27, 2007 O.C.M.E. 00 TUD 1 Oush 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. 32. Registrar's Signature 31. Date filed (Month, Day, Yea State 2007 and the Registrar **ORIGINAL**

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10 Jovember 200-1 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MON IMO NO If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreig Country) Social Security Number Age (In yrs. last birthday) **Funeral** Days Mir 9 117-34-359 Usual Residence of Decedent 1 M 2 XF Yrs Director 0 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No notified Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō must be 212 ashington Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. nt of Health and Mental Hygiene. : If Item 27 Is marked other than "natural", or Iten or other traumatic event, the Medical Examiner. 1 Never Married 2 Married I □ Yes 2 ☑ No f Yes, Give rear or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: Nhite Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16b. (Give kind of work done during most of working life. DO NOT use retired) (Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type. Print) Baltimore, ethod of Disposition MBurial 2 ☐ Cremation 3 ☐Removal from State Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee Um .Balko MD 2522 trickel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deat dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** 0 NOXIC week /Medical Due to (or as a consequence of): **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (of as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Ö ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 ☑Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? the funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA ဥ 1 Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be

completely filled in by within 24 hours a

State

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day,

and address of person who

determined

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DHMH 17 Rev 1/2001

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

completed cause of death (Item 23a) (Type, Print) 3

32. Registrar's Signature

1 Creftfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

07-08930	
Ray Lyne, Jr.	

ay Lyne, Jr.	State of Maryland / Department of Health 1- For State		eg. No. 2007 3845
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	Date of Dea Month	
		vn, or Location of Death	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		rth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	3 5.14	1.3007 MD
iow any	10a. State 10b. County 10c. City, Town or Location Baltimore		10d. Inside City Limits 1 Ves 2 No
Alaryland 28a-f show d at once	10e. Street and Number 10f. Zip C	ode	10g. Citizen of What Country?
death with the Maryland criems 23a or 28a-f sho must be notified at once	314-13	ac7 of Hispanic Origin? (Specify Yes or No	o- 14. Race - American Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify (Cuban, Mexican, Puerto Rican, etc.)	White, etc.
ours afte	lor Dates:	No specify:	Specify: Black 16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exa	Elementary/Secondary (0-12) College (1-4 or 5+)	ng life. DO NOT use retired)	inent
215-0036 be filed within 7 minal Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	Maiden Surname)
2121: hould be fill and Mental I is marked utic event,		(Street and Number or Rural Route Num	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours an ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin or other traumatic by the Medical Examin or other traumatic event, the Medical Examin or other traumatic event ev	20a. Method of Disposition 20b. Place of Disposition (Name		ore M) 21207 20c. Location - City or Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med	1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify:	ematon	Baltimore, MD
Balti permit. Departri Imports	21. Signeture of Funeral Service Licensee 22. Name and Ac	dress of Facility Cremation	n Services Dike Baltimore MD 81839
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.		
kaminer	Immediate Cause (Final disease or condition resulting in death) a. Asi hyxia Due to (or as a consequence of):		Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		-
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6 be executed ysician and burial - transit	d		
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of Vital Records, ag Physician: The law require. the this certificate has been signeral director, page 2 should be not To Be Completed.		auto perfo 1 ✔ Yes	ormed? death?
Tital Recisions The is certificate lirector, page	examiner?	Place of Death (Check only one) Other Nursing Home 5	Residence 6 Other:
ing Physi ling Physi After this funeral dir	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c	c. Injury at Work? 28d. Describe	how injury occurred
Division o spital or Attending hours after death. neral Director: After filled in by the fune Certification:	Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, o	ffice building, etc. 28f. Location (was asphyxiated (Street and Number or Rural Route Number, City
Divospital of hours af muneral Divospital of hours af muneral Divospital Divo	4 Homicide determined (Specify) house		state) Ker In. Baltimore, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	(Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the tire one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.		
A S		icense number D.C.M.E.	29d. Date signed (Month, Day, Year) November 21, 2007
	30. Name and address of person who completed cause of death (Item 23a)		
State	31. Date filed (Month, Day, Year) 32 Registrar's Signature	treet, Baltimore, MD 21201	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
23a per dr. g874 12/03/07dhb
20b per fh
Reg No. Amend Item 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1950 PM Lane John November 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOPKINS The Johns HOSTOITA Himore Date of Birth (Month, Day, Under 24 Hrs. Birthplace (State or Foreign Country) Age Funeral Year Months 1**X**M 2□ F 08/15/196 Director ebenen, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director banor Chancy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7046 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical I once. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine 18. Mother's Name (First, Middle, Maiden Su 17. Father's Name (First, Middle, Last) Be P ane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kichard anime 20b. Place of Disposition (Name of cemptery, crematory or other 20c. Location 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lum Funeral Home 21. Signature of Funeral Service Licensee Jonestein Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Shock Physician /Medical Due to or as a consequence of Examiner trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hepatitis C attending physician and for use as the burial-tran The law requires that the death certificate be exect Due to (or as a consequence of) P.O. Box 68760 Physician/Medical certificate has been signed by the attending physirector, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 12 Yes 2□No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 Impatient Medical Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident Injury To the nours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) ro the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 24,2007 MD 30. Name and address of person while impleted cause of death (Item 23a) (Type, Print)

LUNGSEY COX 600 North Wolfe Street Baltimore, MD Lyndse

DHMH 17 Rev 1/2001

State

Registrar

32. Resistrar's Signature

A Stand

2007

arwell Lincoln	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrer Certificate of Death Reg. No. 2007 3848
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Vegs
Funeral Director	Bon Secours Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. DI/18/1936 Country) Foreign Country)
Maryland 28a-f show any d at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country?
n with the Maryland ms 23a or 28a-f sho be notified at once eral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
rs after death with inral", or items 23 miner must be no Iby Funeral	Armed Forces? 1
imore, MD 21215-0036 Pages I and 2 should be fited within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Innt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	during most of working life. DO NOT use retired) College (1-4 or 5+)
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than matic event, the Medical To Be Compile	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
iore, MD ges 1 and 2 sho at of Health and I: If item 27 is other traumati	Carwell Lincoln LT 7004 Allenswood Rd. Rendaltshorn ub 2183 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State
Baltimore, permit. Pages I au Department of He Important: If ite	4 Donation 5 Other Specify, 21 Jignature of Funeral Service Lightse 22. Name and Address of Facility aughn C. Greene Juneral Structure, MD 8728 Liberty Rd. Randallstum, Mb 21133
Physician 'Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Due to (or as a consequence of):
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated
60, ste be executed hysician and e burial - transit	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED
certifica certifica anding plase as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. es that the grant be detache	1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, gr Physician: The law requires the this certificate has been signeral director, page 2 should be remained to the Commission of the Commiss	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
rital sician: is certii irector	25. Was case referred to medical 26. Place of Death (Check only one)
	7. Masor of Docth 29. Date of John 29. Date of John 29. John 20. Date of John 29. John 20. Jo
Division pital or Attendio ours after death, ternal Director: /	3 Suicide 6 Could not be determined Could not be Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hosp within 24 ho To the Fune completely fi	
	29b. Signature and title of certifier 29c. License number O.C.M.E. November 28, 2007 30. Name and address of person who completed cause of death (Item 23a)
3	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat Registra	
DHMH 17 Rev 1/2001	OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 2007 **Physician** NOVEMBER ADA LEVY 3:01P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6503 PARK HEIGHTS AVENUE, APT. 2-B BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 07/18/1914 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 2XF 215-03-2397 93 MD **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M. dir al Examiner must be notified at 1 X Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6503 PARK HEIGHTS AVENUE, APT. 2-B 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify ģ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL PRUCE FANNIE PUMPIAN ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20015 19a. Informant's Name/Relationship (Type, Print) 4301 MILITARY ROAD, N.W. UNIT 310, WASHINGTON, D.C. PHYLLIS GOLDSTEIN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State HEBREW YOUNG MEN 11/30/2007 BALTIMORE, MD □ Depation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bladder 2015 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**□**/No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

be exect Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

After ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A bletely filled in by the fu death. To the I within 2

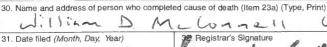
State Registrar

William 31. Date filed (Month, Day, Year) DEC 0 3 2007

0

29b. Signature and title of certifier

29a. Certifier (Check only one)



and manner stated

6301 N. Charles

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

52

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UU Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LEVIN DAVID NATHANIEL November 28 2007 10 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/21/1917 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Yrs. 215-07-6246 90 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director MD BALTIMORE BALTIMORE Northamole, Maryland 21215-0036 10g. Citizen of What Country? 10e. Street and Number 4001 OLD COURT ROAD, APT. #415 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT ACCOUNTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL LEVIN SARAH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau 4001 OLD COURT ROAD, APT. #415, BALTIMORE, MD BERNICE LEVIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State HEBREW YOUNG MEN 11/30/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** END STAGE GANCIERS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any library library library cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, nding physician use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death Natural 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 23th 2927 hysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

25 Main SM 32 Registrar's Signature

			1 - For State Registrar	State of M	aryland / De <i>C</i>	partment of ertificate o			giene Reg. No.2	07	38465		
	Physici /Medio		1. Decedent's Name (First, Middle, Las Davy Lee Mill	er				2. Date of De Month Novemb	Day 27, 0	2007	3. Time of Death		
	Examir Funeral	er	4a. Facility Name (If not institution, give Maryana 676) 5. Social Security Number 6. S	neral x	Josp Hal	Balti	or Location of D	rty		ty of Death	A		
	Director		5. Social Security Number 220-96-2341 6. S Usual Residence of Decedent	M 2□F	36 yrs.	Months Day	s Hours N	Aug. 2	*, Year 1971	Cou	Maryland		
	e Maryland	ctor	10a. State 10b. County MD N/A		10c. City, Town or		altimore				10d. Inside City Limits Y□ Yes 2 □ No		
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and 21215-0036 be filed within 72 hours after deeth with the Maryland tall Hygiene. do other than "natural; or Items 23a or 28s-1 show event, it a Madical Examination must be notilised at	d by Funerai	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1 No	3. Was Decedent of If Yes, specify Cu		? (Specify Yes or No uerto Rican, etc.)		ace - Ameri ack, White ity: Whi				
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yland	Maryla	To Be	17. Father's Name (First, Middle, Last) Edward J. Miller	, Jr.			J	Name (First, Middle, udith Ann	Bryant				
			19a Informant's Name/Relationship (1 Edward J. Miller	, Jr. Fat	her 123	ailing Address (Street Carrol	et and Number of L Street	, Baltimo	er, City or Town re, MD	n, State, Zi 21230	p Code)		
Baltimore,	Page ment ant: if		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of Dis cometery, c Cedar Hi	sposition (Name of rematory or other p III Cemete	ery 12	Date -1-2007	20c. Location Brook	•	own, State Park, MD		
Balt	permit. Depertrimporte		21. Si mature of Funeral Service Lie n	L Dall	sville!	2719 Hamn	nonds Fr	Ambrose Fi y Rd., Lai	nsdowne	Home,	Inc. 21227		
8760, ≪	Cate be executed /Medical /Medical Examiner International /	dicai Examiner	23a. Partf. Enter the disease, or corn shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leaving to annuadrate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Respire Due to (or as b. Set Zi	atory f a consequence of): RR a consequence of): C Enc	enter the mode of different formal of the second se	2	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death		
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Division of	ding P. After fune	Certification:	1 Natural S Pending 2 Accident investigation 3 Suicide 6 Could not be										
Δ	8 S E 90		4 Homicide determined	building, etc. (Specify) 281. Location (Street, factory, office City or Town, St									
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	with To		M. Meratec			80	9574		29d. Date sign	7/07	Z		
	3		30. Name and address of person who a Nukyam Mera	tel, m	, D. 40 1	De. Print) Marylan	a Gene	ral Hos	prtal	2			
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 3 20	32 Regist	rar's Signature	nante s		/					

State of Maryland / Department of Health and Mental Hygiene? 38466 State Registrar Amend 16b, perFH, g874, 12/3/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** AM rances 8:00 Louise November 21 2007 /Medical 4a. Fecility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Sinci Hospital of

5. Social Security Number 6 Baltimore 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ KF 85 217-20-4598 land Yrs. Mary Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iteme 23a or 28a-f ehow L MUrphy 1 Yes 2 No Director timore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2406 154 Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 Frances 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed ◆ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry Afro-15. Decedent's Education (Specify only highest grade completed) American Newspaper, Elementary/Secondary (0-12) College (1-4or 5+) 1ears Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ . Cherry 19a. Informant's Name/Relationship ype, way ter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 a Department of Health ar Important: If Item 27 is any njury or other trau once. CH.MD 21214 Hastor France verland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ナンナス 1 ■ Burial 2 Cremation 3 Removal from State Arbutus Cemeter 4 □ Donation 5 □ Other (Specify) 29/2007 21. Signatur of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Amy loidosis 2 months /Medical Due to (of as a consequence of): Examiner Monodonal aanna, oathu 2 months Securitism list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and * The law requires that the death certificate be executed ettending physicien and * Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown been si Hypertensian 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has the lirector, page 2 s 1 Yes 2 NO Division of Vital or Attending Physician: Diractor: After this certific I in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 No 2 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours aft To the Funeral DI completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, Seath occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 21, 2007 RES-OUD 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD Sinai Hospital of Bultimere sennite 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State DEC 0 Registrar 2007

ORIGINAL

DHMH 17 Rev 1/2001

		For State	Sta	ate of	Maryl			rtment of H		and M	ental Hyg	giene			
		Registrar					Cert	tificate of	Death			Reg. No	10.7	38467	
Physici	an	Decedent's Name (First, Midd									Date of Dea Month	Day	Year	3. Time of Death	
/Medic		Margaret 4a. Facility Name (If not institution		tric		urphy		4b. City, Town, o	r Location o		Novemb		2007 nty of Death	7:50 A M	
Examir	ier	Genesis Heri	_			nter			Dunda					ore Co.	
Funeral		5. Social Security Number	6. Sex			yrs. last birti	hday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birth	1	9. Birthp	place (State or Foreign	
Director		220-30-3996	1 M 2	2XF	73	Y	rs.	Months Days	Hours	Min.	(Month, Day Feb. 1		Cour	vland	
and w		Usual Residence of Decedent 10a. State 10b. County	,		10c	. City, Town	orloc	ation						0d. Inside City Limits	
daryla f sho ed at	ō	Maryland	Baltin	nore						D	undalk		'	1 ☐ Yes 2 ☒ No	
the N 28a-	Director	10e. Street and Number	Darcin					10f. Zip Code				10g. Citizen o	of What Cour	ntry?	
h with 3a or st be		1920 Crafton	Avenue	3					1222			-	ted St	· .	
death	Funeral	11. Marital Status	12. W	as Dece	dent Ever i	in U.S.	13. W	as Decedent of H Yes, specify Cuba		gin? (Spe	cify Yes or No-	14. R	lace - Americ		
ING Z1Z13-UU3D be filed within 72 hours after death with the Maryland tital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medral Examiner must be notified at	by Fu	1 □ Never Married 2 □ Mar	ried 1 [☐ Yes Yes, Give	2 <mark>∏</mark> No			Tes, specify Cuba	Specify:	i, Puerto i	nican, etc.)	Spe	lack, White,		
15-0036 72 hours af "natural", or	q p	3 ☑ Widowed 4 □ Divorced Year or Dates:				16a. Decedent's Usual Occupation					_		white		
IG ZIZIS-16-1 filed within 72 P. I. Hygiene. other than "nate ent, the Medica	Completed	(Specify only highest grade completed) (Give kind of work done during most of work done during most of will be considered).							of working	rking 16b. Kind of Business/Industry					
Z 1 Z 1 Z withir d withir giene. r than the Me	Шо	9 Years	Elementary/Secondary (0-12) College (1-40r 5+)						Own Home						
land id be filed ental Hygicked othe	Be C	17. Father's Name (First, Middle	, Last)			·			18. Mother	r's Name	(First, Middle,				
farylan	70	Joseph Cuda								phie					
Mar d 2 sho d 2 sho th and th and traum		19a. Informant's Name/Relation		•							Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222				
e, n 1 and 1 and Health em 27 ther t		Lisa Murphy-S 20a. Method of Disposition	nyder	(Dau		<u> </u>		O Crafto			andalk,				
ages nt of l		1 X Burial 2 ☐ Cremation		al from S	iale			tion (Name of atory or other place	1				n - City or To		
altimol rmit. Pages spartment of portant: If I y Injury or o		4 □ Donation 5 □ Other (a	Te	17	18	t. St	-	slaus Ce Name and Addre			007	Balti	more,	Maryland	
baltimore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic es		Men !		_ a	U	/	Dı	uda-Ruck 022 Wise	Fune	ral H					
0.01		23a: Part . Enter the disease, o shock, or heart failure. Lis	r complication	ns that ca	used the c	leath. Do n							11Q 212	Approximate Interval Between	
Physician	8 1	Immediate Cause (Final disease or condition	P	NE	iM	20/11	4						4	Onset and Death	
/Medical Examiner		resulting in death)		_		sequence o		4							
LXammer	_	Sequentially list conditions,	b	kn,	1/H	35E	M	A							
nsit red	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	<					ALG							
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c	Due to (c	or as a con	sequence of	f):	ALU	>						
ficate be executed physician and sthe burial-transit	dical		d												
rdifica ng phr as th	- au ⊪	IS SENALS													
ath cer tendin	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?			ome pf pre	egnancy Fetal death	3 □E	Ectopic pregnancy	,				Date of delive	*	
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	hysician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Pregna □Unkno	ant at time wn	of death	5 🗆 (Other (specify)		_	<u> </u>		Month	Day Year	
that the ed by detac	₽.	Part II. Other significant condit	ons contribut	ing to dea	ath but not	resulting in	the unc	lerlvina cause aive	en in Part I.	-	23e. Did to	bacco use co	ontribute to th	ne cause of death?	
w requires to been signed should be	d by							,			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown				
w red	lete										24a. Was a	ın 241	h Were auto	psy findings available	
vician: The lavicetrificate has rector, page 2:	Completed										autop: perfor	sy med?	prior to cor death?	mpletion of cause of	
clan:	BeC	25. Was case referred to medica	ıl		-		-		26. Place	of Death	1 Yes (Check only or	2 No	1 ☐ Yes	2 No	
hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospita	al: 1 🗆 In	patient :	2 □ ER/Outp	patient	3 DOA Oth	er: _/		ne 5 Resid		Other (Specif	y)	
ing P		27. Manner Death 1 Natural 5 □ Pendii		a. Date of (Month	f Injury , <i>Day Yea</i>	28b. Ti	me of jury	28c. Injur Worl	y at k?	2	8d. Describe h	ow injury occ	urred		
storial true functions of the functions	cati		gation not be						Yes 2 1						
after of Direction by	Certification:	4 ☐ Homicide determ	nined 286	buildin	g, etc. (Sp	e <i>cify)</i>	m, stree	et, factory, office		2	8f. Location (S. City or Tow		mber or Rura	I Route Number,	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
Fo the within Fo the younge	Me	29b. Signature and title of certifle		na marin	or orareu.			29c. License	e number		2	.9d. Date sigi	ned (Month, Day, Year)		
		Samon D.	115	TUI	'as	MID		1 0 2	27/	188	2	11/2	Sola	>	
3	ŀ	30. Name and address of person	who complet	ed cause	of death (Item 23a) (T	ype, Pı	rint)	7/			1 1 .	70	- 00	
		avindu	12 10	ulli	aintror's O	1/1	lan	luf /	10ce	_0	und	alk 1	40 0	21222	
Sta Registr		31. Date filed (Month, Day, Year, DEC 0 3	2007	32. He	gistrar's Si	gnature	Gas	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
DHMH 17 Rev 1/20				and the	-20.00	1	September 19								

Michael Joseph Medura

07-09227 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2007 384											
Physician Medical Examine												
Ţ	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 44. County of Death 44. County of Death Anne Arundel											
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or											
Director	220-21-8651 _{1 M 2 F} 21 _{Yrs.} Months Days Hours Min. Nov. 29, 1986 Country) Maryland											
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits											
Aaryland 28a-f show any 1 at once.	Maryland Anne Arundel Pasadena 1 Tyes 2 🕅 No.											
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8352 Forest Drive 21122 U.S.A.											
er death with 1												
fter deal												
hours aft natural" Examine	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry											
5-0036 ed within 72 hour lygiene. other than "natu	Elementary/Secondary (0-12) College (1-4 or 5+) 12 O Mechanic Baltimore Gas & Electric											
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Albert Michael Medura Melanie C Campfield											
212 rould be d Menta is marke	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
and 2 sho ealth and tem 27 is traumati	Melanie C. Medura (Mother) 8352 Forest Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State											
Baltimore, MD 21215-0036 permit. Pages i and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 12-04-07 Brooklyn Park, Maryla											
	21. Signature of Ineral Service Lice 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122											
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva											
/Medical xaminer	aillure. List only one cause on each/line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):											
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60, ate be executed hysician and e burial - transit	UNPENDED AMENDED											
30x 6876 death certificate e attending phy for use as the b	FEMALE: 23c. If yes, outcome of pregnancy 1											
Box 687; death certification attending ped for use as the	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown											
P.O. Best that the degree by the statement of the stateme												
ords, F	1 Yes 2 No 3 Probably 4 Vunknown 24a. Was an 24b. Were autopsy findings available											
Records, The law requires ficate has been sig	autopsy performed? prior to completion of cause of death? yes 2 ✔ No 1 Yes 2 ✔ No											
of Vital Records, P.O. ng Physician: The law requires that if the this certificate has been signed by neral director, page 2 should be detack	25. Was case referred to medical 26. Place of Death (Check only one)											
n of Vi	77 Manner of Death											
Division tal or Attendir rs after death. al Director: A led in by the fu	1 Natural 5 Pending Nov 29, 2007 Pending Investigation Position Pending Investigation Positio											
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To the He within 24 To the Fu completely	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
	Thoday M. VIX The mod O.C.M.E. OCME November 29, 2007											
4	30. Name and address of person who completed cause of death (Item 3a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
Stat	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature											
Registra DHMH 17 Rev 1/200												
OCME ODDC												

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Hospital or Attending To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

Abdallah 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) November, 25, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Koad, Randallstown, MD, 21133 AFrourI

State Registrar

DHMH 17 Rev 1/2001

DEC 03 2007

29b. Signature and title of certifier

Kendall Moseley, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287 31. Date filed (Month, Day, Year) 32, pegistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29c. License number

Res-000

29d, Date signed (Month, Dav. Year)

November 26, 2007

Frace Etta Moor		State of Marylan	d / Departmen <i>Certificate</i>			d Menta	al Hygiene	Reg	. No. 201	07 3847
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Month	Death		3. Time of Death
Medical Exami		GRACE E. MOORE		45	City, Town, or	I and an of		nber 2	Day Year 21, 2007 4c. County of Death	1130 hrs
*		4a. Facility Name (if not institution, give street and numb 7845 Hillsway Avenue	er)		Parkville	Location of			Baltimore Cou	nty
Funeral Director		5. Social Security Numbern 6. Sex 7.	Age (In yrs. last birthda 85	''	If Under 1 Year Months Day		Min.	of Birth 7/19	(MM/DD/YYYY) 9. Bird Foreig 22	hplace (State or n untry) MD
any	F	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	Location				_		10d. Inside City Limits
* "	_	MD BALTIMORE	PARK	VILL	Æ.					1 Yes 2 X No
e Maryland or 282-f show fied at once.	Director	10e. Street and Number		1	Of. Zip Code			100	. Citizen of What Cour	ntry?
with the Maryland ms 23a or 28a-f sho be notified at once.		7845 HILLSWAY AVENUE				234			USA	
ath wit tems 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force	es?				n? (Specify Yes Puerto Rican, etc		14. Race - Ameri White, etc.	can Indian, Black,
hours after death with the Maryland 'natural'', or items 23a or 28a-f she Examiner must be notified at once		3 X Widowed 4 Divorced If Yes, Give Year or Dates:	2 X No	1 Y	es 2X No	specify:			Specify: WH]	TE
hours a	ed by	15. Decedent's Education (Specify only highest grade	duri		Usual Occupa		nd of work done se retired)		16b. Kind of Business/	ndustry
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215-0036 be filed within 72 ntal Hygiene. rked other than "	Completed	2 YEARS 17. Father's Name (First, Middle, Last)				18.Mother's	Name (First, Mi	ddle, M		-
	a	PAUL EDWARDS					ACE MCG			7.0.10
MD 21 d 2 should Ith and Me n 27 is ma	의	19a. Informant's Name/Relationship (Type, Print) HEIDI K. AGNEW/GRANDDAUG			adaress (Stre BON AIF				per, City or Town, State	
nore, MD 2 ages I and 2 shou nt of Health and N t: If them 27 is n other traumatic		20a. Method of Disposition	20b. Place of D	Dispositio	on (Name of ce		E AUGU:	SIA	GA 30907 20c. Location - City or	Town, State
MOF Pages lent of int: If		1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:	METRO C	CREM	ATORY,		11/30/2	200	CATONSVIL	LE, MD
Baltimore, permit. Pages I am Depertment of Heal Important: If Iten injury or other tra		21. Signature of Funeral Service Licensee	- 11						FUNERAL H	
Physician	- 4	239. Part I. Enter the disease, or complications that cau	sed the death. Do not e				BLVD.			1286 Approximate Interval
🧪 'Medical		failure. List only one cause on each line.	tic Cardiovascular							Between Onset and Death
.aminer		or condition resulting in death) Due to (or as a co								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	onsequence of):							
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50, te be executed hysician and burial - transit	Aedical	UNPENDED AMENDED								
38760 rtificate b fing physi as the bu	an/Me	23b. Was decedent pregnant in the		Feta	I death 3	Ectopic	pregnancy		23d. Date of deliver Month	y Day Year
Box 6876 e death certificate the attending physical for use as the	/sician//	1 Yes 2 ✓ No 9 Unknown 9 Unknown	nt at time of death 5	Othe	er (Specify)			_		
O. B at the d d by the	/ Phy	Part II. Other significant conditions contributing to contributing the contributing to contributing the contributing to contributing the contributing to contributing the contributin	eath but not resulting in	n the un	derlying cause	given in Par	t I. 23e		pacco use contribute to	
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/ital	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Input	patient 2 ER/Outp	atient		Other ₄	Check only one) Nursing Home	5 1	Residence 6 🗸 Othe	er: Scene
1 of \ding Phy. After th	n: To	27. Manner of Death 28a. Date of (Month, D	Injury 28b. Tin	ne of Inj		ury at Work?		scribe h	ow injury occurred	
Vision or Attendi filter death. Director: ./	atio	Natural 5 Pending 2 Accident Investigation				Yes 2				North City
Division of Vital Records, pital or Attending Physician: The law require ours after death. Internal Director: After this certificate has been sifilled in by the finneral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	of Injury - At home, farm	n, street,	, factory, office	building, etc		own, S		ural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical C	29a. Certifier 1 ☐ Certifying Physician: To the best (Check only one) 2 ✓ Medical Examiner: On the basis of	examination and/or inve	occurre estigatio	ed at the time, on, in my opinio	date and place on, death occ	ce, and due to the	e cause, date a	e(s) and manner as sta and place, and due to t	ited. he cause(s)
To To To	Me	29b. Signature and title of certifier	ieu.			se number			29d. Date signed (M	
		Mayour The Yn	ell		0.0	.M.E.			November 22, 2	2007
10		30. Name and address of person who completed cause Margarita Korell MD. Assistant Medi		11 Pe	nn Street. I	Baltimore	, MD 21201			
S	tate		strar's Signature	-	ests)					
Regis	4	2-0 0 0 100/1 20	BERIAL AS	100	1 TO 1					

		_	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		F	Reg. No. 200	7 38472
ō.	Physicia /Medic		1. Decedent's Name (First, Middle, L	,	MARIA MU	MMAUGH		2. Date of Dea Month NOV •		3. Time of Death 4:25 P M
	Examin	12000	4a. Facility Name (If not institution, g	,			r Location of Death		4c. County of I	Death
	7. V	امو	SUMMERVILLE AS 5. Social Security Number 6.		EVING e (In yrs. last birthda	WESTMI If Under 1 Year		8. Date of Birt	CARRC	
-	Funeral Director	6	217-14-6942	1□M 2 V F	96 Yrs.	Months Days	Hours Min.	(Month, Day	/, Year)	Birthplace (State or Foreign Country) MARYLAND
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary Fed a	tor	MD CARRO	LL	WESTMI	NSTER				1X Yes 2 □ No
	th the or 282 e noti	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?
	ath wis 23a	ral	45 WASHINGTON			21157			USA	Ai Idi
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Dates:	Ever in U.S. 13	8. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black, \	American Indian, White, etc. WHITE
5-0	72 hc 'natuı dical	eted	15. Decedent's (Specify only highest (Education grade completed)	(Gir	edent's Usual Occup ve kind of work done	during most of work	ring	16b. Kind of Busin	ess/Industry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) life	DO NOT use retire SEAMSTI	,		SEWING	FACTORY
	2 should be filed v and Mental Hygie is marked other i 'aumatic event, th	Be	17. Father's Name (First, Middle, La		RACHUBA		1		Maiden Surname) RISTINE	WAVSON
Maryland	should ind Men marke	욘	19a, Informant's Name/Relationship			iling Address (Street	L			ate, Zip Code 2 0 8 3 3
<u>≅</u>	1 and 2 s Health ar em 27 is ther trau		TERRI GUARDIN		_ 1	_				
ore,	of He of He or othe		20a. Method of Disposition	□Removal from State		position (Name of rematory or other pla		Date	20c. Location - Cit	
Baltimore ,	2 # e a		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe							URG, MD
Bal	permit. Pages 1 a Department of Hes Important: if item any injury or othe	: 3	21. Signature Muneral Street Lice Lice		2	54 E. MA	AIN ST.,	WESTM	INSTER,	L HOME, P.A. MD 21157
	Physician /Medical		23a. Part1. Inter the disease, or conshock, or heart failure. List or Immediate Couse (Final disease or consideresulting in death).	Pn	eumo		ng, such as cardiac	or respiratory as	rrest,	Approximate Interval Between Onset and Death
	Examiner			b Due to (or as	a consequence of):					
	₽ \V ₩	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	~ II				
	and and all-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	TOMILO	ihny			
68760,	rtificate be executed ng physician and e	edical E		d	Monk	Thalla	, disc	case		
	ertifica ling ph e as th	Med	IF FEMALE:				1			
O. Box	law requires that the death certificate be executed as been signed by the attending physician and as 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	
rds, P.	quires that n signed b uld be deta	ρ	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause gi	ven in Part I.	23e. Did t		ute to the cause of death?
Records,	e law rec has bee e 2 shou	Completed						24a. Was autoj	osy prio	ere autopsy findings available
al	n: The ficate har, page		25. Was case referred to medical				00 51 (5	1□ Yes	2 No 1	ath?]Yes 2□ No
or Vital	Physician: this certific	To Be	examiner? 1 Yes 2 N	Hospital: 1 ☐ Inpatio	ent 2 ☐ ER/Outpat	ient 3□ DOA Ot	26. Place of Dea her: 4□ Nursing H		dence 6 XOther	(Specific ASSISTED
o uo	ding Ph h. After th funeral		27. Manner of Death 1 Destural 5 Pending investigat	28a. Date of Inju (Month, Da		y Wo			how injury occurred	
Division	i or Attending after death. Director: After i in by the funer	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of inj	jury - At home, farm, tc. (Specify)			28f. Location (City or Tou	Street and Number wn, State)	or Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		Physician: To the best caminer: On the basis of and manner st	of examination and/or					
	To the within 2 To the complete	Me	29b. Signature and title of certifier	· Oneia	MD		se number) 0 54 21	8	29d. Date signed (Month, Day, Year)
	10		30. Name and address of person w	no completed cause of a		ne, Print) Mallalus	duk,	West	ninta t	10 21157
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature					

Registrar

DEC 0 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** McClelland November 30, 2007 5:45 am M Maria Marguerite /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1400 Spring Avenue Baltimore Rosedale If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Director 92 12/1/1914 215-03-4659 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notifled at 1 ☐ Yes 2X No Director Maryland Baltimore Rosedale 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 once. 1400 Spring Avenue 21237 Funeral S. A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Greenwell LeRoy Marguerite Rudolph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LeRoy R. McClelland (Son) 451 Torner Road Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 2007 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 coloul ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) monding **Physician** years /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine I or Attending Physician: The law requires that the death certificate be executed attendeath.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check o 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 30, 2007 30. Name and address of person who completed cause oldeath (Item 23a) (Type, Print) Road #208, Baltimore, MDZ123.7

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 3

South

32. Re

2007

strar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29, 2007 Month Physician Jessie Viola McGhee November 9:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 2625 Sloatfield Avenue **Baltimore** 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Maryland 218-28-5706 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2625 Sloatfield Avenue 21223 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No 1 Never Married 2 Married 1□Yes 2No Baltimore, Maryland 21215-0036 Specify: White 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Paul Arndt Minnie Ingram ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21222 Darlene Shell / Daughter 6712 Boston Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Good Shepherd 12/01/2007 | Ellicott City, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Se 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final **Physician** 8 months disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusen and Due to (or as a consequence of) as the burial-Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 XYes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 | Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ∏Yes 2 ∏No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

900 CATON AVE BALTIMORE, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

stiar's Signature

31. Date filed (Month, Day, Year)
UEC 0 3

07-09155

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Melvin Miller 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year November 26, 2007 1546 hrs **Medical Examiner** Melvin Miller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital **Baltimore City** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreiar Months Days Hours Director Country) Maryland 1 **⊠**M May 16. 1937 70 219-34-1236 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Maryland Baltimore Woodlawn Yes 2 X No with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21207 United States 2001 Alto Vista Avenue 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Specify: White 1 Yes 2 No specify: hours after Widowed Divorced If Yes. Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 than MD 21215-0036 i 2 should be filed within th and Mental Hygiene. Artist Art 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ermit. Pages 1 and 2 should be filed bepartment of Health and Mental Hyg mportant: If item 27 is marked ott njury or other traumatic event, the Fdith Schmier Melvin O. Miller, Sr. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4274 Maybrook Ct. Concord, North Carolina 28027 Robin Grubb / Niece 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/03/2007 Woodlawn, Maryland Lorraine Park Donation 5 Other Specify 21 Signature of Funeral Service Licenses 22. Name and Address of Facility David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and failure. List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Ĩ Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical UNPENDED AMENDED attending physician or use as the burial -The law requires that the death certificate be P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 Unknown Unknown signed by the a Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed' Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other, DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 ✔ Yes No 28a. Date of Injury (Month, Dey,Year 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural 1 Yes 2 No filled in by the fi Pendina 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after Fo the Funeral Dire 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 29, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 32. Restrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Inde		•	
1- State of Maryland / Departr	nent of Health and Me icate of Death	ental Hygiene Reg. No	25 100 5000
1. Decedent's Name (First, Middle, Last)		Date of Death Month Da	3. Time of Death
Catherine A. Miller		November :	27 2007 0310 AM
4a. Facility Name (If not institution, give street and number) 4b	. City, Town, or Location of Death	4c.	County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE		Baltimore
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Year)	9 Birthplace (State or Foreign
213 62 8128 1 M 2 F 52 Yrs. M	ontris Days Hours Willi.	Dec3,195	
Usual Residence of Decedent			
10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
MD N/A Baltimore			1 ∑Yes 2 No
10e. Street and Number 1	Of. Zip Code	10g. Cit	izen of What Country?
3029 kenyon Ave.	21213		U.S.A
11 Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
1 ☐ Never Married 2X Married 1 ☐ Yes 2 🗙 No		ilicali, etc.)	Black, White, etc.
3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Yes 2√√ No Specify:		SpecifyBlack
15. Decedent's Education 16a. Decedent'	s Usual Occupation of work done during most of workin	16b. K	ind of Business/Industry
(Specify only highest grade completed) (Give kind life. DO N	NOT use retired)	9	
	retary	Har	bor Hospital
17. Father's Name (First, Middle, Last)		(First, Middle, Maider	
James Edward Miller	Mami	e Alle	n
	ddress (Street and Number or Rural		*****
Curtis Scott/Son 4189	Inns Brooks Dr	. Snellv	ille.Ga 30039
20a. Method of Disposition 20b. Place of Disposition	n (Name of Da		ocation - City or Town, State
1 Burial 2 □Cremation 3 □Removal from State cemetery, cremator		2007 DAT	TIO MD
4 Donation 5 Other (Specify) OAK LAWN		ZUU/ BAL	TO, MD.
21. Signature of Funeral Service Licensee 22. Na	me and Address of Facility CALVIN B SCRI	IGGS FUNE	RAI. HOME
CR 1	CALVIN B SCRU 412 E.PRESTON		RAL HOME O. MD 21213
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	e mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition a.	/		Onset and Death
resulting in death) Due to (r as a consequence of):			
Sequentially list conditions. b. Hyperalycev	MIA		
Sequentially list conditions, II any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	1.5.010		
Cause (Disease or injury that initiated events			
resulting in death) Last Due to (or as a consequence of):			
4			
u.			
IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
in the past 12 months?	opic pregnancy ner (specify)		Month Day Year
1 Yes 2 No 9 Unknown 9 Unknown	ler (specify)		
Part II. Other significant conditions contributing to death but not resulting in the under	lving cause given in Part I	23e. Did tobacco	use contribute to the cause of death?
and significant seminations continuously to death but not resulting in the under	.,g oddoo gwell iii i dit i,		
		1 ☐ Yes 2	□ No 3 □ Probably 4 □ Unknown
		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		performed?	death?
25. Was case referred to medical	26. Place of Death		Tilles Zille
examiner?	Other	ne 5 Residence	6 Flother (Specific
27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 2	8d. Describe how inju	
1 Natural 5 □ Pending (Month, Day Year) Injury	Work? M 1	I = = = = = = = = = = = = = = = = =	.,
3 Suicide 6 Could not be 280 Place of injury - At home farm street		Of Loggian (Ctrost	nd Number or Rum! Pouts Number
determined determined 28e. Place of injury - At nome, farm, street, building, etc. (Specify)	raciory, office 2	City or Town, State	nd Number or Rural Route Number, e)
The state of the s			3
29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death on the basis of examination and/or invest			
one) and manner stated.			
29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
· Bederum	D 28683	N.L	OUENBER 29,2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	t)	1 19	-30476.02/, 100/
	AVENUE BALL	TIMORE A	15 21224
31. Date filed (Month, Day, Year) 32 Registrar's Signature	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	1.00,11	
DEC 0 3 2007 December 15 1000	E)		

Registrar

State

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once.

Pages 1 and 2 should be filed within 72 hours after death nent of Heatih and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23

Baltimore, Maryland 21215-0036

Funeral Director

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Physician/Medical

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Certification:

Medical

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or Attending Physician: Within 24 hours after com...

To the Funeral Director: After a commendately filled in by the fur

Division or Vital Records.

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 ☐ Yes 2 X No 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

AT 2438946

HOSPITAL

NOVEMBER 24, 2007

MA

BALTIMORE

M.A. UNION MEMORIAL ANDREEA OLARU,

31. Date filed (Month, Day, Year) DEC 03 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Elizabeth Mary O'Dair Nember 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 8. Sex 7. Age (In yrs. last birthday) 4 Hrs. Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Davs Hours 1 M 2 F Yrs. 213-26-5077 76 May 4,1931 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Running Court 21221 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 20No 1 ☐ Yes 20XNo Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Caterer Gourmet Caters 17. Father's Name (First, Middle, Last) Ukn. 18. Mother's Name (First, Middle, Maiden Surname) Young Agnes Ciganek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Hofmann (Daughter) 21 Running Court Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State MilMop Service Corp 12/3/2007 5 Other (Specify) 4 Donation Towson, Maryland 21. Signature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): S pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

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Injury

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Pages 1 tment of 1 tant: If It ò

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Division or Vital Records, P.O. Box 68760,

Director

Funeral

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The law requires that the death certificate be executed

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certificate has page 2

this funeral the Cirector: filled n by

within 24 hours a Hospital

or Attending Physician:

Examiner

Physician/Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Be	25. Was case referred to medical examiner?	26. Place of Death Check onl one									
10	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	□ Nursing Home 5 □ Residence 6 □ Other (Specify)								
rtification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred 2 □ No								
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
dical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of my knowledge, death occurred at the time, daniner: On the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, and due to the cause(s) and manner as stated. n, death occurred at the time, date and place, and due to the cause(s)								

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2007

cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor 9000 Adedoyin P

31. Date filed (Month, Day, Year) DEC 0

32 Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Francis Wilbur Peters November 29, 200 4c. County of Death 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Joseph Ritchie Hospice Baltimore N/A If Under 1 Year
Months Days 8. Date of Birth (Month, Day, Year) Oct. 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 217-40-7732 65 Director 1942 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1238 Glyndon Avenue 21223 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Air Freshner College (1-4or 5+) Warehouseman Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Edward Peters Susan Elizabeth Keefe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Brown - Sister 2910 Georgia Avenue, Baltimore Highlands, MD 21227 20b. Place of Disposition (Name of Glen Haven 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 □Cremation 3 ☐Removal from State 12-3-2007 Glen Burnie, MD Denation 5 ☐ Other (Specify) Memorial Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and becomes attending physician and Due to (or as a consequence of) Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba use contribute to the cause of death? Division or Vital Records, 2 ☐ No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 20 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann f Death 1 atural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's

			_ For	State	of Marylan			lealth and N	/lental Hyg	giene		
			State Registrar			Cer	tificate of	Death	_	Reg. No. 2	07	38480
ā	- Physicia	an.	1. Decedent's Name (First, Middle	, Last)					Date of Dea Month	Day	Year	3. Time of Death
	/Medic		John		E.	Pi	nter		Novemb			3:00 A ^M
	Examin	er	4a. Facility Name (If not institution	-				r Location of Death		4c. County		. Co
100			Eastpoint Number	csing Hom	7. Age (In yrs.	last hirthchy)	If Under 1 Year	Eastpoint	8. Date of Birth			e Co.
	Funeral		5. Social Security Number	XXM 2□F	90	Yrs.	Months Days	Hours Min.	(Month, Day April 2	r, Year)	Coun	rland
	Director	-	213-09-4399 Usual Residence of Decedent		90				APITI Z	, 1 3 1	rary	Tallu
land	at ow	Ì	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
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deal	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was De Armed I	cedent Ever in U Forces?	.S. 13. \	Was Decedent of H f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White,	
affer SQ	or it		MXNever Married 2 ☐ Marr	If Yes, C			1 □ Yes XXNo	Specify:		Specif	y. Whit	-0
21215-0036 ad within 72 hours af	ural", I Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates: WWI:		dent's Usual Occu	nation		16b. Kind of B		
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CO D	Hygi ther ant, ti	ပ္	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surnai	ne)	
yland 21215-0036 ould be filed within 72 hours after death with the Maryland	ental ced o	To Be			Pint	er		Fann	ie Draks	ler		
- G	PEE	-	19a. Informant's Name/Relations	hip (Type. Print)				t and Number or Ru				
Baltimore, Maryland bermit. Pages 1 and 2 should be file	Department of Health and Mer Important: If item 27 Is marke any Injury or other traumatic once.		Mr. Joseph Kr	all (Bro	other)	412	S. Macor	n Street	Baltimo	re, Mar	yland	3 21224
ore,	item othe	1	20a. Method of Disposition	0 []D	_	Place of Dispo cemetery, crei	sition (Name of matory or other pla	ice)	Date	20c. Location	- City or To	own, State
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ati.	ports ports y Inju		21. Sign turn of uneral Any	gy see	1/4/	D1	2. Name and Addre	ess of Facility Funeral	Home of	Dundall	, Inc	
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			23a. Part . Enter the disease, or shock, or heart failure. List	complications that only one cause or	t caused the deat each line.	th. Do not ent	er the mode of dyi	ing, such as cardiad	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	ysician		Immediate Cause (Final disease or condition	a.	and	IQC	Athes	t				
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8760, xate be executed	physician and the burial-transit	Examiner	resulting in death) Last	Due t	to (or as a consec	quence of):						
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Box eath cert	tendii r use	an/h	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregn e birth 2 Fet		∃Ectopic pregnanc	су			ate of delive onth	ery Day Year
O. E.	the at ned fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□Unl	egnant at time of a known	death 5	Other (specify)_					
P.O.	d by detach	Ph/	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use cor	ntribute to t	he cause of death?
Records, P.O. Box 6 The law requires that the death certific	been signed by the attending I should be detached for use as	Completed by	and CHF	HIN	1 2) V	T			10	Yes 2 No	3 Prol	pably 4 Unknown
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or Vita Physician:	this certificate has al director, page 2	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	☐ Inpatient 2 ☐] ER/Outpatier	nt 3 DOA Ot	her /	lome 5 ☐ Resi		her (Speci	fy)
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SiO endir	eath. or: At he fu	atic	2 Accident investi	igation]Yes 2∏No				
Division or Vital Records, alor Attending Physician: The law requires t	ter de irect n by t	Certification:	3 Suicide 6 Could 4 Homicide detern	ningd Zoe, Fla	ace of injury - At h ilding, etc. <i>(Sp</i> ec	nome, farm, sti ify)	reet, factory, office		28f. Location (a City or To		ber or Run	al Route Number,
ojtal c	eral C		29a. Certifier Certifyi	ng Physician: T-	the best of multi-	owledge deed	th occurred at the	time, date and place	and due to the	cause(s) and n	nanneras	stated
Hos	24 ho Fun etely i	edical	(Check only 2 Medical one)	Examiner: On the	e basis of examin anner stated.	ation and/or ir	nvestigation, in my	opinion, death occi	urred at the time,	date and place	, and due t	to the cause(s)
o the	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	29b. Signature and title of certific				29c. Licen	nse number		29d. Date sign		
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,			30. Name and address of person	who completed ca	ause of death (Ite	m 23a) (Type,	Print)	1 11 00	0 0 -	17.		MA21201
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1	Sta Regist	ate rar	31. Date filed (Month, Day, Year DEC 0	302007	2. Registrar's Sign	A A	bout	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** heliA November 200 Vatt /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner itospital Sount Agnes Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 51-30-0081 1 □ M 2 1 F Georgetown S. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show a or 28a-f show t be notified at 1 THES 2 No Director Md Baltimore 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Black Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ketirement 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ashington UNKnowN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Praitt Baltimore Kevin 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 07 Owings Mills Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic 270 fred-Hilton bar 1. March Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) スカと cervical Cancer metrist **Physician** m on /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours a ler death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifi

MI

30. Name and

Jun

M)

900 Gaton Avenue

Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

29c. License number

47353

29d. Date signed (Month, Day, Year)

ovember 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 **Physician** Day 27 ^Y677 ам Della Pierce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ManorCare Catonsville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 A F Director 216-42-1390 84 03/06/1923 NĆ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

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Department of H
Important: If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 12/03/07 Randallstown, MD 22. Name and Address of Facility Wylie Funeral 638 N. Gilmor St. Balto.,Md 21217 21. Signature of Funeral Service Licensee Home P.A. ones 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burlal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 🔲 Inpatient P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No after death | Director: / d in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: within 24 hours a To the Funeral I

> State Registrar

Medical

29a, Certifier

29b. Signature and title of

31. Date filed (Month, Day, Year)

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certifi

30. Name and address of person who completed cause of deam (Item 2

2007

and manner stated.

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Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 4b, perMD,10c, perFH_0874, 12/3/07 TT amend item 19a per inf 8878 4-9-08 vertically state of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month NOV.2 ,2007 /Medical EDWARD **OUARLES** SR 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3407 YATARUBA DR. ESSEX Woodlawn BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG. 21, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Country) 1□ M 2□ F 216 24 9638 77 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☐ No BALTIMORE MD. ESSEX Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 YATARUBA DR. 21207 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11thSTEEL WORKER BETHLEHEM STEEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES QUARLES NARCISSUSS TYNES 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCESCA DARBY (daughter) 5694 LEIDEN RD. BALTIMORE, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; if ite
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PK. NOV.30,2007 BALTO, MD. Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 412 E. PRESTON STREET BALTO, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TYY MUMA :4 montys /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1□ Yes 2€ No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ∏No ours after death.
neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a **To the Funeral C**completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 4940 EATTER AVE BALTIMIR Md 2,224 JHBVML PURTE 11 MILYAUL 31. Date filed (Month, Day, Year) 32, Registrar's Signature State DEC 03 2007

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Wylie Robinson, Jr. 11 25 2007 5:22p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2711 Spelman Road Baltimore NA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 4-7-1.944 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1**火** M 2□ F 212-42-1442 Director 63 Md. Usual Residence of Decedent a or 28a-f show be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Md. NA 1 X Yes 2 □ No Director 10f. Zip Code 21225 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Apt. A l 2711 Spelman Rd. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robinson, Sr. Mary Wylie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2406 Bytham Ct. 104, Baltimore, Md. Wiley Robinson Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11-30-07 Baltimore, Md. Greenmount Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signatura of Puneral Serpice Licensee March F.H. East -while-1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) achiovauller dis Physician par lunive /Medical Due to (or as nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has lirector, page 2 autopsy performe Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DCA 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

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filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Pate signed (Month, Day, Year) D28266 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 5010 YORK Rd, BALTO. MD 21212 HUE LWIN istrar's Signature 31. Date filed (Month, Day, Year) 32

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

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Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. Decedent's Name (First, Middle Last 2. Date of Death 3. Time of Death **Physician** Day Month Year 9:02 PM /Medical 27 2007 Movember 4a. Facility Name (If not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bouhnare Ury nder 1 Year | If Under 24 Hrs. Balhinare itospiral Social Security Number 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 213-82-7300 Months Days Hours Director Usual Residence of Decedent 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Co. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced 21215-00 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Be 683 Baltimore, 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Liq routo, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or hear follure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Haute Cerchellor Layel da /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dilated Cardionizabai Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Patient

State Registrar

DHMH 17 Rev 1/2001

Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DEC 0 3 2007

31. Date filed (Month, Day, Year)

			State of Maryland / Departme	ent of Health and Mental Hygic	ene 107 38486
				ate of Death Reg	g. No. 2001 30400
	Physic	ian	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
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	Director		220-20-4/0/ 10 M 2 F 79 Yrs. Monti		Year) 9. Birthplace (State or Foreign Country) 928
	g ,		Usual Residence of Decedent		in giana
	ehov	2	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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	me 23	Funeral Director			14. Race - American Indian,
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Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	and Address of Facility ass Fundra	1 Service P.A.
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ecc	has be	Completed	- hoot /llees	24a. Was an	24b. Were autopsy findings available
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	1		30. Name and address of p risch who completed cause of death (Item 23a) (Type, Print	1053, Cheun	ethic
	Sta	e	31. Date filed (Month, Day, Year) 37 Registrar's Signature	egot any	NO 41045
	Registra		UEC 0 3 2007		₩ P

DHMH 17 Rev 1/2001

Michael A. Scott	State of Maryland / Departmen 1- For State Certificate Registrar	it of Health and Mental Hygie e <i>of Death</i>	ne Reg. No. 2007 3848
Physician/	Decedent's Name (First, Middle,Last)		ite of Death 3. Time of Death
Medical Examine	4a. Facility Name (if not institution, give street and number)		vember 27, 2007
	4a. Facility Name (if not institution, give street and number) 5207 York Road Apt. 402	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	2/3 44 3780 1XM 2 F 6/	Yrs. Months Days Hours Min.	7-/3-/946 Country) M. &
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Baltimore, permit. Pages 1 a Department of He Important: If ite	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Phillip	A MEATHER FORD FS PA
	23a. Part I/ Enter the disease, or complications that caused the death. Do not e	2431 E. OlIVER ST BA	116 MB 2/2/3
Physician /Medical	failure. List only one cause on each line.		iratory arrest, shock, or heart Approximate Interval Between Onset and Death
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e law e has lee has lee has lee has lee namel			autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No
tal Re- tiant. The certificate ector, page		26.Place of Death (Check only of	
of Vital Recting Physician: The After this certificate funeral director, page 700 mr. To Be Con	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other Nursing Ho	me 5 Residence 6 🗸 Other: Scene
ing Pt After After Tuneral			Describe how injury occurred
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Hospit 4 hour Funers ely fill	29a, Certifier		207 York Rd. Apt 402 Baltimore, MD to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	(Check only one) 2 Medical Examiner: On the basis of examination and/or invegence and manner stated.	estigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
F 3 F 8		29c. License number	29d. Date signed (Month, Day, Year)
	Donne Me monti, MD.	O.C.M.E.	November 28, 2007
D	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	1201
State	2 31. Date filed (Month, Day, Year) 32 Registrar's Signature		
Registra	DEC 0 3 2007		

07-09178 Lillie M Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 38488

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		4	la. Facility Name (if no	t institution, give	street and number)		Baltim		, Doda,				
			Sinai Hospital 5. Social Security Number	ber 6. Se	y 7 Age (In	yrs, last birthda	av) If Unde	r 1 Year If Unde	r 24Hrs. 8	. Date of Birth(MM/DD/YYYY	g. Birth	place (State or
	neral ector		· ·	-4174			Months Yrs.	Days Hours	Min.	11-27	8/15/19	Foreign Cour	ntry) SC
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with	Hygiene. or items 23a or 28a-f show of ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.		11. Marital Status	•	12. Was Decedent Eve		Was Decede If Yes, specif	nt of Hispanic Orig y Cuban, Mexican	gin? (Speci , Puerto Ric	ify Yes or No- can, etc.)		e - America te, etc.	an Indian, Black,
death	nust	Ĕ	1 Never Married		1 Yes 2	No		No specify:			Specify:	BI	ack
after	al", o	ğ	3 Widowed		If Yes, Give Year or Dates:	od) 16a De		Occupation (Give	_	k done	6b. Kind of B		
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215-0036 be filed within 7	_ D _ 1	Be	Henry (C. MCF	adden			E	thel	Aust		- Ot-to	Zin Codo)
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m §	`E. Ē Ğ,		2 WI	my	plications that caused the	death Do not	enter the mode	York od	cardiac or r	espiratory arre	st, shock, or h	neart	, wp. 0,01110111
	sician edical		failure. List only	one cause on e	ach-line.								Between Onset and Death
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387 artifica	ling p		23b. Was decedent pr past 12 months?	regnant in the	1 Live birth Pregnant at tin	2 ne of death =	=	3 Ecto	pic pregnar	icy	Month	,	Day
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n c	tending eath. tor: Afi the fun	i i	1 Natural	5 Pending				1 Yes 2		shunt e	rosion		
isic	er dea	ical	2 X Accident	Investig 6 Could n	28e Place of Inju	ry - At home, fa	arm, street, facto	ry, office building	, etc.	28f. Location (Street and Nu State)	ımber or F	Rural Route Number, City
	italor irs aft ral Di	Certification:	3 Suicide 4 Homicide	determi	ned (Specify) Of	ther-res							Baltimore, MD
Division of Vital Records, P.O. Box 687	To the Hospital or A within 24 hours after To the Funeral Dire			Certifying Phys	ician: To the best of my	knowledge, dea	ath occurred at	he time, date and	place, and	due to the cau	se(s) and mar	nner as sta nd due to	ated. the cause(s)
	To the Hos within 24 h To the Fur	Medical	one) 2	Medical Exami	ician: To the best of my ner:On the basis of exami and manner stated.	ination and/or i	nvestigation, in	my opinion, death	occurred a		and place, di	110 000 10	Ionth, Day, Year)
D	- ≥ - 6	, S	29b. Signature and t	title of certifier	A] *	29c. License numb	per		Novemb		
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	B				no completed cause of de	an (Item 23a)	11 Dann Str	eet, Baltimore	MD 21	201			
	40		Zabiullah Ali		sistant Medical Exa		A CAME	ost, Daltimore	J, Z I				
		State	1 1 1-	h, Day, Year)	32. Registrar	Sugnature	STORES OF			OCM			
	N:36	istra	_ UL	- V V V									

State Registrar

31. Date filed (Month, Day Year) 2007

Margarita Korell MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. registrar's Signature 10 8218 J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Owen Leonard Sevison 09 A M 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manyland Madica athmare Center N/A 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 27,1949 Birthplace (State or Foreign Country)
 Maryland 6. Sex 7. Age (In vrs. last birthday) 1 M 2 □ F Yrs. 218-58-6693 58 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2KINo Maryland Middle River Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? United States 21220 3306 Iris Lane 12. Was Decedent Ever in U.S. Armed Forces? ↑ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 200 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Truck Driver Petro Express 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Owen Leroy Sevison Gladys Georgia Schultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3306 Iris Lane Middle River, Maryland 21220 Mrs. Kathleen C. Sevison (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 11/30/2007 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Scharachnoic CERTIFICATION NOPROVED BY MEDICAL EXAMIN Due to (or as a consequence of) Sequentially list conditions, any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown

Physician /Medical Examiner

Important: If it any injury or o

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division or Vital Records,

or Attending Physician:

To the I

certificate be

other traumatic event, the Medical Examiner must be notified

or items 23a

"natural",

s 1 and 2 should be filed within of Health and Mental Hygiene.

Exami and as the burialattending physician Physician/Medical use 5 the ģ þ Completed has certificate Be P this Certification: After within 24 hours arter community to the Funeral Director: Af

IF FEMALE:

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

11-25-07

and manner stated.

24a. Was an autopsy performed? 1□ Yes 2 1No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

26. Place of Death (Check only one) Hospital: 1 Mpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

12:15 1

28c. Injury at Work? 1 ☐ Yes 2 No

Street Baltimare, MD

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

fell of Subject fell off root.
281. Lot ion (Street and Number or Rural Route Number,
25th or Town, State) Lane
Middle River, Marylane

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

River, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

25. Was case referred to medical examiner?
1 ☐ Yes 2☐ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

State

Registrar

4 ☐ Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Inier 31. Date filed (Month, Day, Year)

> 3 200

DEC 0

2 32 Registrar's Signature

22

DHMH 17 Rev 1/2001

11

Pat	rick Timothy	/ Sw	1- For State	State of Maryl		artment of rtificate of		Mental F		gibie.	007 001
Ma	Physic		1. Decedent's Name (First, Mi	. ,					2. Date of Dea		3. Time of Death
ivie (dical Exam	me	PATRICK TI 4a. Facility Name (if not institu			14	lb. City, Town, or L	ocation of Deat		Day Year r 25, 2007 4c. County of	1228 nrs
*			924 Regester Aven	Je			Towson			Baltimore	
	Funeral Director		5. Social Security Number 215–66–4553	6. Sex	7. Age (In yrs. I	•	If Under 1 Year Months Days	If Under 24Hr Hours Min	n		Birthplace (State or Foreign
			Usual Residence of Decedent	1 X M 2 F		52 Yrs.			Feb 2	1, 1955	Country) Maryland
	v any		10a. State 10b. Coun	•		, Town or Locati					10d. Inside City Limits
	yland I-f shov once.	ţţ	Maryland Balt 10e. Street and Number	imore Coun	ty	Idlewy					1 Yes 2 X No
7	he Mar or 28s	Director	924 Regeste	r Avenue			10f. Zip Code	1239	1	0g. Citizen of Wha	•
7	eath with the Maryland items 23a or 28a-f show any ust be notified at once.	uneral	11. Marital Status	12. Was De	cedent Ever in U		s Decedent of Hisp	anic Origin? (S			- American Indian, Black,
	or death or ite	Fun	1 Never Married 2	1 Yes	2 X No		es, specify Cuban,		o Rican, etc.)	White,	
	urs afte tural"; amine	d b	3 Widowed 4 X	Divorced If Yes, Give Yes or Dates: pecify only highest gra			Yes 2 X No		work done	Specify: 16b. Kind of Bus	White
	6 72 hor in "na cal Exa	letec	Elementary/Secondary (0-1			during me	ost of working life. I	DO NOT use re	tired)		·
	within within giene.	Completed	17. Father's Name (First, Midd	1 1	yr	Mail	Carrier				tal Service
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	Thomas Aloys		ey, Sr.		11		e (First, Middle, E il een]	Maiden Surname) Egan	
	21 Should Ind Mer	2	19a. Informant's Name/Relation		ther)			and Number or	Rural Route Nur	nber, City or Town	, State, Zip Code)
	and 2 stem 27 traum		Mary E. Sweet	ley (Mo	•		tion (Name of cem	•	Date		yland 21239 City or Town, State
	nore		1 X Burial 2 Cremat		om State	crematory or oth	er place)				more, Maryland
	altir rmit. P spartme sportsu jury or		4 Donation 5 Other 21. Sin re f Frenzial Sør	Specify:						AL HOME,	
		V 12	Mar tin D. Lav 23a. Part I. Enter the disease,	vs611		65	00 York	Road, B	altimore	e, Maryla	and 21212
	Physician /Medical	3 %	failure. List only one cau	se on each line.					or respiratory arr	est, shock, or hear	rt Approximate Interval Between Onset and Death
	xaminer		Immediate Cause (Final disea or condition resulting in death		ene intox		nd cocaine	use			Death
		<u>۱</u>	Sequentially list conditions, if any, leading to immediate	b.	consequence o	٤١.					
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	3760 ficate l g physis the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes,	outcome of preg	nancy				23d. Date of d	· ·
	Box 6876(death certificate the attending phyadron use as the b	iciar	past 12 months?	4 Pregr	ant at time of de	oth	aldeath 3 er (Specify)	_Ectopic pregn	ancy	Month	Day Year
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	Reco	omp				-			autop perfo 1 ✔ Yes	rmed? de	rior to completion of cause of eath? Yes 2 No
	Vital Rec ysician: The I his certificate I director, page	BeC	25. Was case referred to medi examiner?					f Death (Check			
	of Vi ing Physi After this uneral dir	မ	1 Yes 2 No 27. Manner of Death	Hospital: 1	of Injury	ER/Outpatient 28b. Time of In				Residence 6 V	_
	on on carding sath.	Certification:	1 Natural 5 Pe	nding Fnd 1	, Day,Year) 1/25/2007	Fnd 12:0	. 1 v	s 2 X No	unk	now injury occurre	u
	ivisi or Att after de Direct	tifica	3 Suicide 6 X Co	uld not be	_,,		, factory, office bui	lding, etc.	28f. Location (r or Rural Route Number, City
	ospital hours meral y filled	Ser	4 Homicide de	termined (Specify)		in rehab.		home		ster Ave. I	Towson, MD
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	5 1 1 2	Me	29b. Signature and title of certi	and manner s	tated.		29c. License	number		29d. Date signed	d (Month, Day, Year)
	0,		1 our. 12		MID.		O.C.M	.E.		November 2	26, 2007
j	4-1		30. Name and address of personal M. Vincenti, N	· ·	e of death (Item ledical Exam	,	Penn Street, E	Baltimore, M	1D 21201		
		~~~	31. Date filed (Month, Day, Year		gistrar's Signatu	- 3	des				
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#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2:30p 24, November 2007 William Joseph Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1711 Summit Avenue Halethorpe If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) Feb. 18, 1916 Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) **Funeral** 234-12-1755 1 XM 2 □ F 91 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore Halethorpe 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1711 Summit Avenue 21227 U.S.A. Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 NYes 2 No If Yes, Give Year or Dates: 1942 - 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aluminum Production 12 Metallurist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Allen Thomas Minnie Vernie Cobun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Distefano/Daughter 1106 Vernon Avenue Arbutus MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial 11-27-2007 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Elkridge, Maryland □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 Part 1. Enter the disease of complications that caused the death. The not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arterio Scherotic Cardio Vascular diseas Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical attending pl If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death □Yes 2 No detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 0

SAMBANDAY BASKACAN

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

3455 WILKENS AVE BALTIMORE, MD 21229

29d. Date signed (Month, Day, Year)

November 26, 2007

			For State Registrar		State	of Maryl	and / Dep <i>Ce</i>		nt of H te of D			ental Hy	giene Beg. No.	2007	384	93
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per dr., g87/e/1/26/201/07/dkdath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year .Month **Physician** Lorraine Wiegmann November 18 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospital N/A Harbor 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours 216-16-3406 83 Yrs Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Examiner mus; be notified at MD N/A Brooklyn Park 1X Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 606 Sunset Strip 21225 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Restuarant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Colbert Esther Colbert ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 SUnset Strip, Brooklyn Park, MD 21227 19a. Informant's Name/Relationship (Type. Print) Robert A. Wiegmann - Husband 20b. Place of Disposition (Name of Wesneter A premater of rother place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 22 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) **∆** □ Donation Crematory 11-20-2007 | Odenton, MD 22. Name and Address of Facility . Signature of Funeral Ambrose Funeral Home, 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thrive Failure 40 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) 6 months Examiner Dementia Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and a betached for use as the burial-transit Depression 6 months Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1□Yes 2□No Month Day Year 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page 1∐ Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner' Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? Certification: Injury 5 Pending investigation М 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

To the Hosi within 24 ho To the Fund completely f

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Konanim, mD 32 Registrar's Signature

RESUDO

29d. Date signed (Month, Day, Year)

29c. License number

11/18/2007

Harbor Hospital, Balhmore MD

31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

DEC 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2, per State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner romwell 8. Date of Birth (Month, Day, Year) 1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Gountry) **Funeral** Min. Months Days Hours 1 M 2 □ F 216-20-5002 Usual Residence of Decedent **Director** 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Be Completed by Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. Yes 2□ Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) econdary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1101/12 rnest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Bart. ML Health tem 27 i 39S 20a. Method of Disposition permit. Pages 1
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any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, ed by the attending physician detached for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9☐Unknown 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 2 No 3 Probably 4 □Unknown 1 TYes To the Hospital or Attending Physician: The law requin within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No premia 24a. Was an autopsy performed 2 No 1□ Yes Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31291 11/12/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sute 4202 70 wsai N Chicks 31. Date filed (Month, Day, Year) 6701 Klorsz 32. Registrar's Signature State DEC 0 3 2007 Registrar Richard Sand

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31. Date filed (Month, Day, Year)

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	Examir		4a. Facility Name (If not institution, Ellicott City F	give street and nu	mber)	Center	4b. City, T	own, or	Location of t Cit	у	B. Date of Birth	4c. Co	4c. County of Death  HOward  9. Birthplace (State or Foreign		
	Funeral Director		579-26-1614 Usual Residence of Decedent	1 M 2 M F	81	Yrs.	Months	Days	Hours	Min.	Month, Day une 17	(, Year)	Cour	nace (State of Foreign ntry)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Medical Examinar must be routiled at ODGs.	To Be Completed by Funeral Director	10a. State 10b. County  Maryland Howard  10e. Street and Number 6715 Aspern D  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify only highest Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, L. Clarke Loy Mory  19a. Informant's Name/Relationshit Leonard Eugene  20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Specify County) 21. Signature of Funeral Service Lie	Drive    12. Was Dac Armed Find   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   1   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes	edent Ever in Unress? 25 No ve lates: 1-4or 5+)  / Husban State 20b.	16a. Dece Give life. I Admini 19b. Mailir ac 6715 Place of Dispo cometery, crer	10f. Zip (2 2 10 7 5 2 10 7 5 2 10 7 5 2 10 7 5 2 10 10 10 10 10 10 10 10 10 10 10 10 10	ont of History Cubar of No  Occupa of done do a retired)  ive  (Street a. cn Dies of ner places  Cem.	Specify: tion uning most  Assis 18. Mother Ruth nd Number rive,	of working tant tant Eli: or or Rural Da Nov.	ify Yes or Nocican, etc.)  First, Middle, Zabeth Route Number	14.  Sp 16b. Kind  Unive Maiden Su Garti r, City or Tc MD 21 20c. Locat Silve	USA Race Amening Black, White, pecify: White of Business/In ersity  rell own, State, Zip 1075 tion - City or Toler Sprii	can Indian, etc. e dustry  of Marylar  Code)	nd
8760,	Personned Medical Medical Examiner	dical Examiner	23a. Fant. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to bDue to	caused the dea pach line.  On SCI (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect	th. Do not entered to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of							Spring,	MD 20901 Approximate Interval Between Onset and Death	
O. BOX 68	ne death certif the attending hed for use a:	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknoyn	1 ☐ Live i	tcome of pregn birth 2 Feta nant at time of cown	aldeath 3□	Ectopic pred					23d	I. Date of delive Month	ery Day Year	
ecoras, P.	requires pen sign hould be	Completed by Ph	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	nderlying cau	use give	n in Part I.			es 2 N	No 3 Prob	ably 4 Unknown	
Vital R	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:					_		perform 1 Yes Check only or	ned? 2 No	death? 1 ☐ Yes	2□ No	1
DIVISION OF	To the Hospital or Attending Physician: whith 24 hours after deals. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification; To	27. Manner of Death   Natural 5   Pending investiga 2   Accident 3   Suicide 6   Could no	28a. Date (Mon	of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury	28s	c. Injury Work 1	Nur	28 lo	d. Describe h	ow injury o			-
N	ospital or A hours after of uneral Direc ly filled in by	- 1	4 Homicide determin	Physician: To the	of Injury - At h	y) owledge, death	occurred at	t the time	e, date and	l place, an	City or Town	n, State) ause(s) an	d manner as s	I Route Number,	
		Medical	one)		ner stated.			1 3				o I D		2	
	10		30. Name and address of person with Ramark Sa bar 31. Date filed (Month, Day, Year)	no completed caus	se of death (Iter	n 23a) (Type	Print)  CK R	ive	1	cck	Road	d E	Mce Hi	1 an	
	Sta Registr		31. Date filed (Month, Day, Year)	307 R	egistrar's Signa	ature	Mi)		-		,	- (	~ [14	y yezy	_

DHMH 17 Rev 1/2001

		•	For State Registrar	State of	f Marylar			of Health ar of Death	nd Me		ene 0 0	7	38498
			Decedent's Name (First, Middle, La.	st)					2	. Date of Death Month		V	3. Time of Death
	Physici /Medic		Clara Viola Ander	son					1	November	17, 2	Year 2007	11:30 A ^M
	Examin		4a. Facility Name (If not institution, giv		nber)		4b. City, To	own, or Location of	Death		4c. County	of Death	
			1339 Lake Shore I	r.			Oakla	and			Garre	ett	
1	Funeral Director		185-22-7223	ex □ M 2 <b>[X</b> F	7. Age (In yrs.	last birthday) 79 ^{Yrs.}	If Under 1 Months		Min.	Date of Birth (Month, Day, 1)	^(ear) 1928	Cour	lace (State or Foreign htry) nsylvania
	and *		Usual Residence of Decedent  10a. State 10b. County		10c, Ci	ty, Town or Lo	ocation			<del> </del>			0d. Inside City Limits
	sho	5											1 ☐ Yes 2 🛣 No
	28a-1	Director	MD Garre	ett	Oa	akland	10f. Zip C	ode		100	g. Citizen of W	/hat Cour	itry?
	with se or	흐	1339 Lake Shore D	120			2155				USA		,
	ns 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	I.S. 13.	Was Deceder	nt of Hispanic Origi	in? (Specif	fy Yes or No-	14. Race		an Indian,
0	riter	F	1 Never Married 2 Married	Armed Fo 1 ☐ Yes	2 🔀 No			Cuban, Mexican,	Puerto Ri	can, etc.)		k, White,	etc.
ğ	urs a	þ	3 Widowed 4 Divorced	If Yes, Giv Year or D			1 □ Yes 2√2	No Specify:			Specify.	W	hite
o O	within 72 hours after deeth with the Maryland ene. Itan "natural", or Items 23a or 28a-f show Ita Medical Exaciliar must be incitled at	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usual (	Occupation done during most of	of working	11	6b. Kind of Bu	siness/In	dustry
Z	thin 9	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	retired)	o,g				
2	filed w Hygier other th	S	12			Home	emaker_				Dwn Hom		
Maryland 21215-0036	Ø 7 2 2	Be	17. Father's Name (First, Middle, Last,							First, Middle, Ma	aiden Sumam	θ)	
<u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </u>	should be ind Mental is marked o umatic eve	ို	James Taylor					Clara					
<u>a</u>	es 1 and 2 should b of Heelth and Ment filtem 27 is marked r other traumatic		19a. Informant's Name/Relationship (			1		Street and Number					Code)
a)	1 and 1eelth em 27 ther tr		Marjorie E. Funk/ 20a. Method of Disposition	Sister	20h (	19298 Place of Dispo		ett Hwy.,	Oak.		2155 Dc. Location		own State
وّ	Pages nent of t int: If It		1 ABurial 2 Cremation 3		State	cemetery, crei	matory or othe	er place)					
Baltimore,	it. Part rtant rtant njury		4 □Donation 5 □ Other (Specifical Service Licer		Ga			m. Garder Address of Facility					
Ba	permit. Page Department of Important: If any injury or		Lycer S	Jeura	au)			ox 275, G				.536	F.A.
			23a. Part : Enter the disease, or com shock, or heart failure. List only	plications that of one cause on e	aused the deat ach line.	th. Do not en	ter the mode of	of dying, such as ca	ardiac or r	espiratory arres	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	nary Ar		isease					У	ears
	Examiner				oras a consec etes Me		Type	тт					ears
I		ē	Sequentially list conditions if any, leading to immediate		or as a consec		туре	<u> </u>		-		у.	ears
	be executed sicien and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
o o	en ar en ar rial-tı		resulting in death) Last	Due to	or as a consec	quence of):	_					П	
8760	ate he	dlcal		d									
Õ	leath certific attending pl	Med	IF FEMALE:								I	1	
Rox	death certific e attending p id for use as	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	aldeath 3	Ectopic preg				23d. Date Mor		ery Day Year
- 0	0 0 0	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregn 9☐Unkn	ant at time of o	death 5L	Other (spec	:ify)					,
عة	The law requires that the de sie hes been signed by the a page 2 should be detached f	F.	Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in the u	inderlying cau	ise given in Part I.		23e. Did toba	icco use contr	ibute to t	ne cause of death?
Vital Records,	sign d be	Completed by	hypercholesterole							1 ☐ Yes	2 1 No	3 🗌 Prot	abiy 4 Unknown
Ö	w require been si should b	ete								24a. Was an	24h V	Vere auto	nsy findings available
Ř	siclen: The law certificete hes l irector, page 2 s	duc								autopsy perform	ed?	leath?	psy findings available mpletion of cause of
Ø		Ö	25. Was case referred to medical					26 Place	of Death (	1 ☐ Yes 2 € Check only one		Yes	2LJ No
5	s cert	To B	examiner?	Hospital:	Inpatient 2	] ER/Outpatie	nt 3 DOA	Othon	-	Residen		er (Specif	iv)
ō	Phys er this eral dir		27. Manner of Beath		of Injury th, Day Year)	28b. Time o		. Injury at Work?		d. Describe hov			,,
<u>o</u>	Attending Physician: In death.  Cotor: After this certific by the funeral director,	atlo	1 Natural 5 Pending 2 Accident investigatio		in, Day 16ai/	Injury	М	1 ☐ Yes 2 ☐ N	lo				
Division of	F = -	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	289. Place	of Injury - At h	ome, farm, st	reet, factory, o	office	28	f. Location (Stre City or Town,		er or Rura	al Route Number,
	Hospita 4 hours Funaral (ely filled	Medical C	(Check only 2 Medical Example 1997)	niner: On the b	asis of examina	owledge, deat ation and/or in	h occurred at	the time, date and my opinion, death	d place, an	d due to the cau at the time, dat	use(s) and ma	nner as s	tated. the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and man	ner stated.		290 1	License number		ەر:	d. Date signed	(Month	Day Year)
	8 4 5 4		200. Organization and title of certified	11/			200.	N/T)	75	> 23	11/10	7/	>
			20 Normand and	U V	a of do-15 //	= 02a) (T	Deien	4122	مرد		11	40	
		IA	30. Name and address of person who Thomas G. Johnson			Fourt		Oakland,	MT	21550			
	Sta	i <i>U</i> te	31. Date filed (Month, Day, Year)		Begistrar's Sign			oaktand	TI <b>U</b>				
	Registr		NOV 1 9	2007	Madlace .	K 1	Joseph )						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Lee SARA ANDERSON 26 2007 0152 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS **CUMBERLAND** ALLEGANY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Ye March 18 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 8 1926 1 M 2 XF 81 West Virginia 215-26-6707 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at 10b. County Grantsville MD. Garrett Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 891 Dorsey Hotel Road 21536 United States Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ ☎0 If Yes, Give Year or Dates: 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify: Specify: 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse s 1 and 2 should be filed w f Health and Mental Hygier Item 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul McCoy Nellie Hanna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Anderson/ son 116 Park Ave., LaVale, Maryland 21502 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 11/26/ 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Cumberland Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Seprice Licensee Boal Funeral Home 7.Wagner 111 Church St., Westernport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? yes 2 No page certificate I 1☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar 29b. Signature and title of certifie

VIKA A In cull ty
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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m.D. 32. Registrar's Signature 29c. License number

D18769

29d. Date signed (Month, Day, Year)

Seton Drive, Cumber land, Mary land

			For State	State	of Maryla	-	artment of H		and Me	-		007	38500	
C			Registrar  1. Decedent's Name (First, Middle	2. Da			2. Date of De	Pate of Death 3. Time of Death						
	Physici /Medic		Carol Winona B				Month 11/7/2007 Year 12:30pmM							
	Examin		4a. Facility Name (If not institution 2710 Summerview				4b. City, Town, or Location of Death Annapolis			4c. County of D		ounty of Death nne Aru		
- 1	Funeral	_	5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year Months Days	-		8. Date of Bird	th	9. Birth	place (State or Foreign intry)	
i	Director		218-36-9834 Usual Residence of Decedent	1 □ M 2 🖳 🛣		69 Yrs.	Working Buys	riodis	1	(Month, Da 8/1/1	938	NO	•	
	yland now at	Director	10a. State 10b. County		10c. (	City, Town or Lo							10d. Inside City Limits	
	Ba-f sh		MD Anne A	olis				1 ☐ Yes 2 🛣 No 10g. Citizen of What Country?						
	with th	Dire	10e. Street and Number 2710 Summerview	Way #102			10f. Zip Code 21401				10g. Citizei	n of What Cou	intry?	
Baltimore, Maryland 21215-0036	death ms 23	Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2010 of If Yes, Give Year or Dates:			U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14.	Race - Amer Black, White		
	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Fu					1 ☐ Yes <b>212</b> No Specify:			icari, etc.)	Specify: White			
	'2 hour natural ical Ex	ted l	15 Decedent's Education 16a, Dece				dent's Usual Occupation				16b. Kind of Business/Industry			
	ithin 7 ne. han "r e Med	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)				kind of work done during most of working DO NOT use retired) d Service				AAC Public Schools			
	filed w Hygie other t	To Be Co	17. Father's Name (First, Middle,	Last)		100	d Bervice		er's Name (	(First, Middle,			ee genoorb	
	uld be Aental rked c		Unknown				Unknown							
	es 1 and 2 should to the alth and Meni item 27 is marked rother traumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Maili				-	g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	1 and Health em 27 other t		Norman E. Brown 20a. Method of Disposition	Son	20b		Youngston State of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market of The Market		Da	agersto ite		1D 217		
	Pages nent of I int: If ite		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		matory or other plac t Memoria	1	1/13	/2007	Annar	oolis,	MD	
Salti	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service			22	2. Name and Addre	ss of Facilit	y Haro	desty	Funera	al Home		
_	905 # 9		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line.  Approximate Interval Between											
	Physician		Immediate Cause (Final	Α.				19, 50011 05	our diac or	respiratory a	11001,		Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)  a. ATHEROSCUEROSIS  Due to (or as a consequence of):											
	Examiner	o Be Completed by Physician/Medical Examiner	Sequentially list conditions,		b. HUPERTENSION									
BOX 58/50,	rted   		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	Due to (or as a consequence of):									
	e execu an and rial-tra		resulting in death) Last	C. Due to (or as a consequence of):										
	death certificate be executed e attending physician and of for use as the burial-transit			d										
	leath certific attending p I for use as		IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome pf pregnancy						23d. Date of d		very	
ă.	death		in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ☐ Fetal death 3 ☐ Ectopic pregnancy nt at time of death 5 ☐ Other (specify) n					Month Day Year				
as, r.c	hat the od by the detache		9 ☐ Unknown  Part II. Other significant conditi	underlying cause given in Part I.			23e. Did t	23e. Did tobacco use contribute to the cause of death?						
	w requires that the d been signed by the should be detached		DIABETES MELLITU							18 Yes 2 No 3 Probably 4 Unknown				
Records	2 23 23									24a. Was		24b. Were aut	topsy findings available ompletion of cause of	
	: The cate had page						perfo 1□ Yes	performed? death?						
or vital			25. Was case referred to medica examiner?  1   Yes 2 No	26. Place of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the state of Death (Check only on the s				one)  dence 6 □Other (Specify)						
	ig Phys ter this neral di	<b>-</b>	27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of Injury				3d. Describe				
SIOL	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	catio	1 ☑ Naturai 5 ☐ Pendir 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation				M 1 ☐ Yes 2 ☐ No						
DIVISION		Certification:	4 Homicide determ				et, ractory, office		28	28f. Location (Street and Number or Ru City or Town, State)			ral Route Number,	
		Medical Co	29a. Certifier  (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	o the lithin 24		one)  29b. Signature and title of certifie	29c. License number				29d. Date signed (Month, Day, Year)						
	F ≯F 8		Price 9	woof	N			6177	+6			MBER_	9,2007	
	iiih		30. Name and address of person	who completed cau	se of death (It	em 23a) (Type,								
(	JA 10		BRIAN E W. 31. Date filed (Month, Day, Year)	32.1	ll 6	D OF EN	SE HWY	, 80	TE "	400,	14nn	POLIS,	MARYLAND	
	Sta Registr			3 2007	Eleve	nature	Sperke							